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## ORIGINAL ARTICLES.

### TREATMENT OF ERYSIPELAS WITH HYPODERMATIC INJECTIONS OF CARBOLIC ACID.

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Having noted in the discussion of a case of erysipelas, before the Louisville Clinical Society, that Drs. A. M. Vance and J. M. Krim lay great stress upon the local application of carbolic acid, I feel prompted to give my experience confirmatory of its efficacy when used hypodermatically in this disease.

About twenty years ago my attention was directed to this remedy by a report of successful results in an English medical journal, and, finding that it fulfilled all that was claimed for it, I have employed it frequently in all the various forms of erysipelas which have come under my care. It has been attended with invariable good effects in promptly arresting the progress of this disease. In some cases no other treatment has been employed, so as to test its virtues without resorting to constitutional measures, and the effect has been entirely satisfactory.

I recall only a single case during all this period, which did not yield to this treatment and that was in a patient, to whom I was called in consultation, at an advanced stage of erysipelas, involving the entire scalp, accompanied with coma. As an offset to this, I have frequently employed the carbolic acid hypodermatically when the scalp was partially involved in erysipelas, with complete relief.

I am reminded by the allusion of Dr. W. H. Wathen, during the same discussion, to complications of delivery at term with erysipelas, of a case in which there was a face presentation, requiring prodalic

version and followed by erysipelas of the genitalia and the hypogastric region. The injections, hypodermatically of carbolic acid in various portions of the area affected was crowned with complete success.

The formula employed by the original reporter, when name is not remembered, was a solution of carbolic acid in dilute alcohol. But this was modified by me afterwards, and I have used during the past ten years the following:

<b>R</b>	Carbolic Acid.....	fs i
	Glycerine.....	fs iii
	Distilled water.....	fs iv

Mix and inject hypodermatically one syringe-ful in each portion of the size of a hand, daily.

It will be observed that this is a 12½ per cent. solution, and only in a few cases has any local irritation resulted from the injection.

When the thickened and hardened condition of the skin has rendered it difficult to introduce the needle, I have selected points on the border of the dermatitis to make the injection, so as to reach the areolar tissue beneath the skin. There is little pain connected with it. I am convinced that many cases of erysipelas will yield to this treatment; but it does not preclude the resort to any internal means which may be indicated, and when the extent of surface involved is large or the febrile condition is great I have used internal remedies.

The best effects have been secured by giving at the outset calomel, followed by Epsom salts in senna tea, to procure free

evacuations from the bowels. After purgation I have given 25 drops of the muriated tincture of iron every three hours until an ounce is taken. In some cases chlorate of potash in 10 grain doses has been combined with the iron, especially when there is a tendency to the phlegmonous form of erysipelas.

But when I am called early to the case and find the erysipelas circumscribed, I rely upon the hypodermatic use of the formula given above and rarely have any occasion to employ other means of cure.

An instructive case was presented a few years after commencing the use of this remedy. Having treated an acute case of erysipelas in the family of a man, he informed me that he was subject to a periodic recurrence of this disease in his feet and legs, every Spring. I had an understanding with him to give me notice of the next appearance, with a view to test the remedy in this chronic state. In the course of time I was called, and found a well developed case of erysipelas on both legs, extending up to the knees. The carbolic acid was used hypodermatically in two places on each leg, and repeated on two successive days, without any other treatment. All traces of the disease dis-

appeared, and during five years subsequently there was no return of the disease, nor did there seem to be any threatening of future trouble.

In this instance the elimination of disease was complete and indicates a specific action of carbolic acid in the cure of erysipelas.

The influence upon the system of such an injection is general and not confined to the immediate location of the puncture, so that it may be considered as a constitutional impression of the remedy. Some caution is requisite against an undue quantity of this solution of carbolic acid being used on one occasion, but a toxic influence is manifested. But I have repeatedly introduced a syringe-full of the solution in four different places, without producing any untoward effect, and hence it may be allowed that this quantity, distributed over an area of four hands' breadth, is entirely safe. It is also found proper to repeat the injections daily for three days, but I have never had any occasion in which it was requisite to continue the treatment for a longer time. My patients have generally been so far relieved within three days or less time, as to dispense with further injections.

## LAVAGE IN THE TREATMENT OF DISEASES OF THE STOMACH.

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I have noticed, from time to time, articles in our medical journals on the treatment of dyspepsia, and have been surprised at the want of mention of one of the most important adjuncts to the treatment of almost all forms of stomach difficulty, viz., Lavage, as practiced by Dr. Dujardin-Beaumetz, of Paris, France.

I have for several years paid special attention to diseases of the alimentary canal and have given much thought to washing the stomach, having in the last five years washed every case of chronic stomach trouble that has presented itself to me for treatment. In the first place it seems to be the only rational means we have for a certain diagnosis of the character of disease the patient may have, for as all know the term dyspepsia conveys little if any meaning, being only a symptom of an organic disease.

I would like to give some of my experience with the straight tube. I always have my patient present him- or herself, from four to six hours after having eaten, when I usually find the stomach free of all food. If, after trying to introduce my tube there be much reflex irritation, I at once introduce about one ounce of a saturated solution of Calcium sulphide to reduce this state, which it does. After having filled the stomach about one-third full of plain water, at a temperature of about 112° F., I syphon this first water off into a clean vessel, saving this result for diagnostic purposes. I continue to use plain water during the first sitting 'til the water returns through the syphon as clear as when introduced into the stomach. I then make my examination of the first liquid and usually diagnose my case from that.

I have treated many cases of ulceration of the stomach, with the most gratifying results, both to the patient and myself, by using in these cases first a solution of resorcin, washing thoroughly with this aseptic water, after which I use about 3i of Bismuth subnitrate to a pint of water, letting this water remain in the stomach about two minutes and then syphoning it off, thereby coating an aseptic sore with the Bismuth.

In atonic dyspepsia, when the muscular walls are so much relaxed as to hardly perform any function, the continued ingestion of hot water seems to impart to them a stimulation and, with the addition of large doses of Strychnia sul., will regenerate an almost worn out stomach.

I have had case after case of catarrh of the stomach, where the mucous glands have been stimulated to such an extent that their secretion overrides all others, and where I have been able to syphon at my first washing not less than one pint of a thick, viscid mucous, so heavy that it sinks to the bottom of the receptacle like lead. Almost complete relief is given in these cases by the employment of an antiseptic wash, followed by the use of arsenate of Copper in  $\frac{r}{16}$  grain doses each morning, taken in a glass of hot water. This form of dyspepsia is the most common and persistent that will come to the physician, and requires great patience on the part of both physician and patient.

Another very prevalent form of dyspepsia is what is known as putrid indigestion, where the patient's stomach fills with the accumulating gasses of putrefaction and causes not only pain to himself, but disgust to his friends who are unfortunate enough to be associated with him. In this form it has been my custom to use a solution of permanganate of potash until the reflex shows the entire absence of organic matter in the stomach which will occur after the injection of about one gallon of water.

I could go on and mention the different forms of disease of this most important organ treated by lavage with proper medication, but hardly think it worth while, as I leave it to the physician to use his own judgement as to what is required in each form. What I wish to impress is that the unpopularity

of this method of treatment of disease of the stomach is due to the fact that almost all practitioners use the same solution in every case that presents itself, whereas each form of dyspepsia requires a separate and distinct form of medication as does any other disease. If the physician will first of all diagnose his case, his own knowledge of medicine will indicate the treatment required, and I can assure him, after an experience of many years, that the results will prove satisfactory.

#### Special Exercise to Correct and Prevent Constipation.

Friction, rubbing, or massage over all parts of the abdomen two or three times per day by the patient himself, or less frequently by a good magnetic operator will help promote vital action of the bowels. If not convenient for the patient to walk or ride for exercise, he can secure the advantage of both in large degree by the following exercise taken in his room:

Standing with the feet well apart to broaden your base, bend or flex the lower limbs at the knees and extend the same about twice a second, or one hundred times a minute, for several minutes at a time, three or four times a day, and at the same time twist or turn the body above the hips first to the right and then to the left as far as you well can, resting the hands upon the hips or allowing them to hang by your side. At each turn of the body toward the right or left you will bend the knees about three or four times. You thus use chiefly the flexors and extensors of the thighs, and the rotating muscles of the trunk. The motion of the body is meanwhile up and down, and the motion of the chest and head is alternately to the right and left. To facilitate the turning of the body, the heel of the limb opposite the one on which you rest, as the body sways from side to side, may be raised so as to allow the limb to turn upon the ball or toe of the foot. To get the best effect of this exercise the head must be kept well up, the shoulders back and the spine erect during exercise. The bowels may generally be allowed to rise and fall with the body, but at times it is well to exercise the diaphragm by endeavoring to draw up beneath it the liver and viscera of the abdomen.—Dr. Dutton, in *Jour. Amer. Health Society*.

## COMMUNICATIONS.

REMOVAL OF THE GASSERIAN GANGLION AS THE LAST OF  
FOURTEEN OPERATIONS IN THIRTEEN YEARS  
FOR TIC DOULOUREUX.\*

W. W. KEEN. M.D.,† AND JOHN K. MITCHELL. M.D.,‡

## MEDICAL HISTORY BY DR. MITCHELL.

J. T. K., aged forty-one years; married; dental surgeon. Until his thirtieth year he was in excellent health, and had no indications of any tendency to neuralgic disease. The history was in every way a good one up to the beginning of the present trouble, with the exception that he was born after a labor prolonged for four days.

The patient was small but strongly built, though when first seen in a much reduced state physically, and in a condition of severe nervous and moral prostration. There is a marked difference in the color of the two eyes, the right one being brown and the left blue.

In 1880, without any previous warning, he had a sudden attack of violent pain in the right upper jaw, nearly limited to one tooth. This came on during a meal. The tooth was extracted, but the pain continued in the socket from which the tooth was withdrawn until this healed, when the pain began in another tooth, and the process was repeated until three were drawn. Only one of these, the twelve-year-old molar, which had been filled some years before with tin and amalgam, was found in an unhealthy condition. The roots were perfectly dry and the foramen very much enlarged. Some portions of the alveolar process, it is said, came away with the extraction of this tooth, and this was also dry and unhealthy-looking. The following summer a portion of bone of that alveolar margin was removed for necrosis. After the parts were healed the pain ceased, with the exception that occasionally at the side of the molar tooth

a sharp pain, like that of an exposed nerve, was felt if the part were touched. This also disappeared during the following few months.

In February, 1881, while washing his face, the patient felt a pain shoot through the infra-orbital region, which increased in severity from day to day until he had to stop work on account of it. After a deal of suffering, his physician, Dr. Kirk, of Fox Chase, brought him to Dr. R. J. Levis, who after examination thought that the pain was caused by the gums contracting so as to press tightly upon the nerve radicles. This he attempted to remedy by cutting loose the gum from the bone for the whole depth of the process, both on the palatal and buccal sides; but no benefit was felt from the operation, and later Dr. Levis cut down upon the infra-orbital nerve at the foramen and removed a small portion of the nerve, again without succeeding in relieving the pain.

After suffering great agony for some weeks, Mr. K. was advised to have his upper teeth extracted. In the attempt to do this the eye-tooth was broken in the gum, and the root could not be removed until Dr. Garretson extracted it some time afterward, and in examining the mouth found a necrosis of a portion of the upper jaw, which he removed.

For a short time the pain in the face was much better, but became finally so very severe in the region of the infra-orbital again, that Dr. Garretson cut down upon the infra-orbital nerve and removed all the portion interior to the foramen, finding the nerve intact. This was in September, 1881.

No further operation was done until February, 1883. Mr. K. matriculated in the Philadelphia Dental College in 1881, but on account of his sufferings was obliged to desist from work. In the spring of 1883, pain returned in a small area in the side of the upper jaw, and the sixth operation, undertaken by Dr. Garretson, re-

\* Read before Philadelphia. Co. Med. Soc. February 14, 1894.

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moved a portion of the upper jaw, exposing the antrum. The patient had comparative ease until the fall of 1883, when the pain began again, and he was variously treated during the succeeding four or five years without much relief.

In the winter of 1887-88 he suffered dreadfully, and in March Dr. Garretson made a resection of the second division of the fifth nerve on the affected side, this being the seventh operation, but how much of the nerve was removed is not stated.

In March, 1889, the third division of the fifth nerve, back to the foramen ovale, was resected by the same surgeon, with much relief; but the pain soon returned, and the ninth operation was the ligation of the facial artery in 1890. In September of the same year, the tenth operation took place—an excision of the whole upper jaw. In September, 1891, Dr. Garretson did the eleventh operation, by opening, at the patient's request, the inferior dental canal and removing the nerve as far forward as the foramen.

From each of this frightful series of operations the patient experienced some temporary relief, with the exception of the one or two otherwise noted. On admission to the Orthopædic Hospital and Infirmary for Nervous Diseases, in May, 1893, he was suffering from three or four paroxysms of severe pain a day, for the relief of which he was taking half a grain of morphine twice a day, and more if the attack was too painful to bear. The right face was sunken, wasted, and seamed with the scars of the several operations; and, in spite of the removal or cutting of the various branches of the fifth nerve, the upper part of the face was still very sensitive, so that to twitch the eyelid, or scratch the right eye, would cause a violent outburst of pain in the *lower jaw*, running forward to the corner of the mouth.

An area of diminished sensation was found upon the outside of the cheek extending from the lobe of the right ear throughout the distribution of the fifth nerve, under the right eye to the median line of the nose and to the median line of the lips. Sensation was not lost in this area, but much diminished, and heat and cold were perfectly distinguished throughout the region.

A few days after his admission a small corneal ulcer was observed upon the outer side of the right eye, midway between the pupillary margin of the iris and the periphery.

The first week in June, Dr. Weir Mitchell and Dr. Keen had a consultation and decided to examine the condition of the inferior dental nerve, in view of the possibility of its having regenerated as to cause the pain which centred in the lower jaw. The severity and frequency of the paroxysms by this time had somewhat diminished from those which occurred on his admission to the hospital, but the smallest movement of the tongue against the cheek or lips would cause paroxysms; to open the mouth at all widely, to put a finger against the cheek, would all bring on furious pain. A small portion of the right cheek immediately below the eye was totally anæsthetic to touch, extending from near the middle line on the right of the nose down to and including the ala of the nose and out upon the cheek about one and one-half inches. The right angle of the mouth was capable of very little movement, and the lower eyelid was almost completely paralyzed.

The site of most severe suffering was not at this time at the mental foramen, but about an inch posterior to it. From this point the pain spread throughout the inferior dental distribution.

Removal of the Gasserian ganglion was proposed by Dr. Keen at this time, but as the patient preferred that a new attempt upon the inferior dental nerve should be tried first, Dr. Keen consented to this, and on June 10, 1893, operated.

#### SURGICAL HISTORY BY DR. KEEN.

An incision was made in the line of one of the old scars near the lower border of the lower jaw. The soft parts being lifted at the site of the mental foramen, a very minute opening was perceived to which the soft parts were adherent by a little thread which may have been a nerve but which tore with slight traction. About an inch and a quarter back of this supposed mental foramen was another quite large foramen corresponding to the focus of pain, from which came out what appeared to be a nerve, which spread out fan-like in the soft parts. This was excised and placed in Müller's fluid. Between the two foramina a button of bone

was removed, but no canal and no nerve could be discovered. I then chiselled away the bone back to and under the large abnormal foramen just mentioned, and found the inferior dental nerve as a thick cord, and followed it backward to the inferior dental foramen. When I seized the nerve to extract it from its bed, although the patient was profoundly anesthetized he struggled considerably. An inch and a quarter of the nerve was resected from the abnormal opening backward, the nerve being drawn down as far as possible. The upper opening was then closed by a sheet of sterilized gold-foil and the lower portion of the bone, where it had been trephined half through its substance and chiselled backward, was filled with dental cement made of oxide of zinc powder and glacial phosphoric acid. The operation was characterized throughout by exceedingly troublesome hemorrhage, which Dr. K. tells me was characteristic of the former operations also. A dozen strands of silkworm-gut were laid in the wound for drainage, and the wound closed and dressed as usual. He made a prompt recovery. Neither the gold-foil nor the cement has given the slightest trouble.

On the 24th of August he was re-admitted, having suffered much pain again for a month. He describes the pain as being in the right cheek, coming on in paroxysms, induced by eating, talking or any movement of the lips, teeth or cheek. The slightest stroking of the cheek will bring it on. He has no pain if the parts can be kept absolutely immovable. The areas of paræsthesia on the right side of the nose and cheek seemed to be somewhat more sensitive, and this time the pain complained of is all above the level of the inferior maxillary. In the absence of Dr. Keen, Dr. Wm. J. Taylor operated again on the 28th of August, removing the tissues about the infra orbital foramen, with only temporary relief. Early in September the pain had returned as violently as ever, and even large and frequent doses of morphine failed to relieve him. Accordingly he re-entered the infirmary in October, with the intention of undergoing the removal of the Gasserian ganglion.

*Operation*, October 18, 1893, by Dr. Keen. One-thirtieth of a grain of strychnine and a quarter of a grain of morphine were given him just before beginning the etherization. An omega-shaped

incision was made, the length of which, vertically, was three inches. One leg terminated immediately in front of the tragus, the other just in front of the junction of the anterior and middle thirds of distance between the external auditory meatus and the external angular process. The temporal artery was cut and this and a few other vessels required ligation. Dr. M. H. Cryer, with the new surgical engine of S. S. White & Co., and a circular saw one and a half inches with a guard, then rapidly and very successfully divided the external table, excepting the two extremities. Here, fearing perforation before the inner table and the rest of the flap were divided, I determined to chisel through. I first chiselled the superior four-fifths of the flap, passing through the inner table with ease, and then chiselled the extremities. At the posterior terminus when I was only giving an ordinary light blow with the mallet, the chisel suddenly penetrated the skull to a depth of perhaps half an inch, and immediately a considerable hemorrhage showed me that the posterior branch of the middle meningeal had undoubtedly been cut. I then chiselled quickly through the anterior extremity, broke the bone and reflected the flap. Here again was an additional trouble, for the anterior branch went through a distinct canal at the anterior inferior angle of the parietal bone, and of course was torn and bled freely as I turned down the flap of bone and scalp. A finger over each artery, however, almost controlled the hemorrhage, and in a very few moments I was able to place a pair of hæmostatic forceps on each. A cut was seen in the dura corresponding in length to the width of my chisel. A small curved Hagedorn needle was then passed first around the anterior branch in the dura, then the posterior branch was caught. The opening in the dura was sutured by catgut. The middle lobe of the brain was then lifted with care and great gentleness from the bone, but this was followed by hemorrhage which might well be called alarming. Lifting up the middle lobe with a spatula, I discovered that it was not, as I had feared, from the middle meningeal ruptured at the foramen spinosum, but that the blood came from the neighborhood of the ganglion. I could not think, with the gentleness I had used, that the cavernous sinus had been ruptured, but

at all events it was too free, not only to allow of removal of the ganglion, but for the integrity of the man's life if it continued. The hemorrhage did not yield to hot water. I packed it twice with gauze which arrested it temporarily, but on removing the gauze it bled as freely as ever. Accordingly I packed in a considerable piece of iodoform gauze and closed the flap by six retention stitches, with the intention of removing the packing in two or three days and then removing the ganglion. Before packing, the dural wound was closed by a stitch of catgut.

no spots in the eye ground. A field roughly taken shows no limitations.

21st. (Third day.) Since the operation the patient has done well, excepting that he has had, of course, a number of paroxysms of pain. The only evidence of increased intra-cranial pressure due to the gauze, has been a slowing of the respiration down to from six to ten, and a slight aphasic condition. The gauze was introduced on the right side of the head and he is a right-handed man. The highest temperature was 100.8° F.

To-day I opened the wound, which was

FIG. 1



Shows the natural size of the piece of iodoform gauze (37 x 6 inches) packed in the cavity of the skin for three days without harm; seen edgewise.

During the operation he had received in all one-eighth of a grain of strychnine, and an hour after the operation was completed was in bed with warm extremities, a pulse of 80, temperature of 98°, but a respiration of only 8 in the minute but very deep. His color was very fair.

October 20th. His eyes were examined by Dr. G. E. de Schweinitz, who reported as follows: "Irides unlike in color: right brown and left blue. Pupils very small, right smaller; reaction normal. Scar in right cornea. Oval optic disk, paler than normal; veins full and larger than usual; arteries normal. No swelling of disk and

partly united. The small cut in the dura, made by my chisel three days before, was entirely closed, and there was not the slightest evidence of any harm from it. I drew out the gauze very carefully, keeping a stream of hot water playing on it all the time so as to loosen it very thoroughly. I found on measurement that the piece was 37 by 6 inches. (Fig. 1.) It weighed 2½ ounces, and a similar piece, dry, weighed 2½ drachms, showing that it had absorbed 17½ drachms of blood. (Fig. 2.) On withdrawing it I was very fearful at first that the hemorrhage, which was moderately profuse, would again prevent my

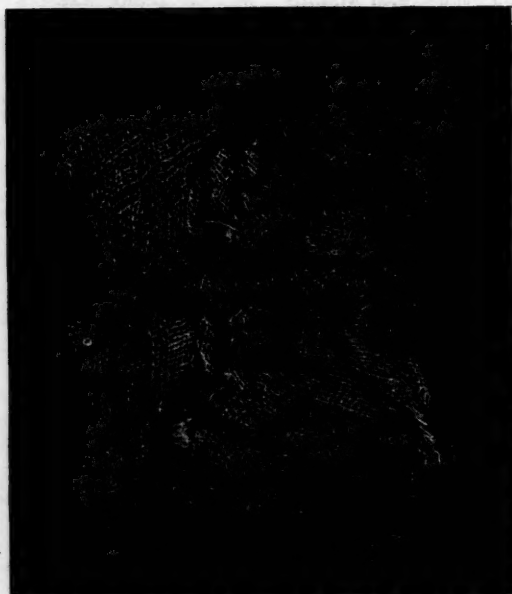
doing anything to the ganglion, but on introducing some small hot sponges I was able to overcome the bleeding in the course of a little while by the heat and pressure. Evidently the hemorrhage did not come from the cavernous sinus, nor from the middle meningeal, both of which I found to be intact.

In a few moments I was able to expose the middle meningeal artery and the second and third divisions of the fifth

The wound was then closed and the usual dressings applied. The patient's condition both throughout the operation and at its end was decidedly better than at the operation on the 18th.

He made a complete and rapid operative recovery and was out of bed on the fourth day, the entire wound being healed. The highest temperature was 101.2°. The aphasia gradually bettered and finally disappeared. He complained bitterly of pain

FIG. 2.



The same piece of gauze; seen side-wise.

nerve, and see also the little flap of dura which covered the ganglion. I had great trouble in separating the third division from the middle meningeal, as they ran very close together. Moreover, both at the second and third divisions, the slightest touch of the blunt hook, Allis's dissector, scissors, knife, anything, produced the sudden escape of at least a drachm of blood, which obscured the field of operation. Pressure by a small gauze sponge for a very few moments would cause the bleeding to cease, but the slightest manipulation produced its recurrence again. However, after cutting both of these nerves and tracing them back to the ganglion, I tore the little extra-dural sac open, and with the Allis dissector and a small sharp spoon I thoroughly destroyed the ganglion.

in the head at first, but this soon diminished, especially after the roots of two teeth were kindly removed by Dr. Cryer. Soon after the operation, the morphine being stopped after the first five days, he had the most intense mental depression. In fact, this went to such a degree and assumed such delusional forms that I was doubtful whether it was due to possible cerebral changes from the three days' pressure of the gauze, or to the withdrawal of the morphine alone, and I seriously feared a permanent insanity. Bromides, strychnine, and sulphonal were all used in turn and in full doses, but none of them did him any good. Finally, codeine in  $\frac{1}{4}$ -grain doses in the twenty-four hours gave him relief in sleep and checked his delusions, so that in a few days he was quite recov-



ered, and since then until the present date, February 14, 1894, has been absolutely rational, free from delusions and pain, and without any desire for his morphine, which on the contrary he loathes after thirteen years of slavery to its use. His eyes were examined by Dr. de Schweinitz, and found to be in the same condition as on October 20th. Glasses were fitted which gave him excellent vision.

(Fig. 3.)

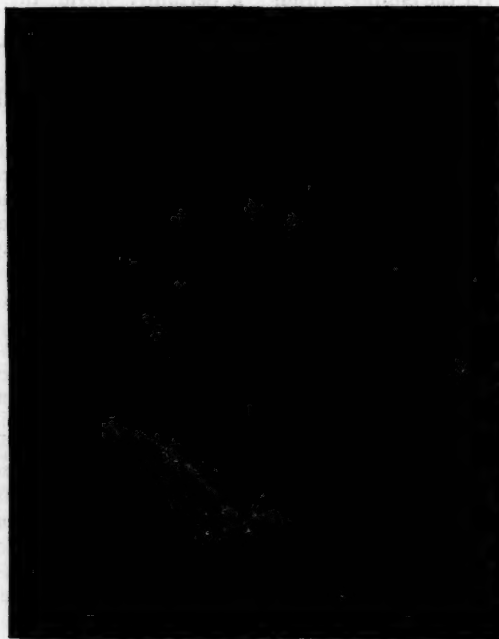
His condition, from a neurological standpoint, will be stated by Dr. J. K. Mitchell.

#### REMARKS BY DR. KEEN.

First, as to the method of operating. Horsley's operation by a temporal flap, opening the dura and tearing the roots of

Krause.† The table (*vide infer*) shows that thus far they are equally safe. There is much more room for the manipulations by this method than by Rose's, in which one to a great extent works in the dark, through a very small opening. Moreover, Tiffany§ has made the important observation that a deliberate opening of the dura, by allowing the escape of considerable cerebro-spinal fluid, gives much additional room for the intra-cranial manipulations. It will be noticed that the two ends of my incision were placed the one directly in front of the tragus and the other in front of the junction of the anterior and middle thirds of the distance between the external auditory meatus and the external angular process. By examining the skull I have found that this marks, as nearly as may be, the anterior limit of the middle

FIG. 3.



The patient after recovery, showing scars of various operations.

the fifth nerve behind the ganglion from the pons, seems to be needlessly severe. As between the Hartley-Krause operation, which I adopted, and that of Mr. Rose,\* through the base of the skull, I think there is no question that the easier operation is that devised by Dr. Hartley,† and soon afterward and independently by

fossa of the skull, and gives, therefore, the widest opening possible for access to the interior. It has the disadvantage that it impinges upon the canal, if there be one, for the anterior meningeal; but anyone accustomed to controlling hemorrhage in the skull should certainly be able to cope with this difficulty, and if the artery,

\*British Med. Journ., 1892, i. 53.

†Annals of Surgery, May, 1893, p. 571.

‡Arch. f. klin. Chir., xliv. p. 821.

§Annals of Surgery, February, 1894.

as is usual, does not run in the canal, no trouble will occur. The advantage of making the flap of scalp and bone, as was done by the osteoplastic resection of Wagner-Wolff, instead of trephining, is, I think, very great, the larger opening being an advantage of the first moment. Moreover, the two ends of the incision should be carried well down, almost to the level of the zygoma, so that the middle fossa will be opened almost completely down to its floor, otherwise the manipulations are much more difficult. The division of the skull by Dr. Cryer with the surgical engine was only moderately satisfactory as to speed. Since then I have had made, at the instance of Dr. E. T. Darby, a drill with two spiral threads which answers the purpose very much better on account of the rapidity with which it divides the bone. Dr. Cryer has figured another drill for the engine, which he says will work more rapidly, but with which I have had no experience. The diagram seems to me to point toward a successful instrument.† In dividing the posterior portion of the bone, it will be noticed that my chisel, by a blow which was not deemed to be too severe, penetrated the cavity of the brain to some extent, but also, what might have been a serious complication and was for a time an embarrassing one, divided the posterior branch of the middle meningeal. This accident has cautioned me as to the use of the chisel. Instead, I should have used Hartley's or some similar osteotome, which, being conical throughout instead of with parallel sides as the chisel had beyond the bevelled edge, would have prevented this accident.

Unfortunately, also, I had to deal with a "bleeder" as was proved by the prior operations, and I presume this was the reason why the hemorrhage was so profuse on the gentle lifting of the temporo-sphenoidal lobe in the middle fossa. No one with ordinary prudence would attempt to remove the Gasserian ganglion while the field was filled with blood, as fatal injury might be done to the carotid or to the cavernous sinus which lie in such immediate proximity to the ganglion. I think the introduction of the gauze, following the suggestion and practice of Krause in his first operations of this sort, was the wisest step I could have taken. The

hemorrhage three days later, when I removed the gauze, was comparatively profuse, but the operation was successfully completed. I was very much surprised, however, when I withdrew the gauze to find that I had packed in so large a piece. It covered 222 square inches, and formed a large wad, which, as it will be observed, had absorbed two ounces and a drachm and a half of blood. It has puzzled me a good deal to account for the absence of symptoms other than the slowing of the respiration and the slight aphasia, as a result of such a large foreign body within the cranium. Possibly a little might be accounted for by the slight yielding of the flap; possibly more by the slight escape of cerebro-spinal fluid by my puncture of the dura; but allowing for all this, the foreign body was a very large one, which must have produced a great deal of pressure. I certainly never introduced so large a piece before, and the fact that four days after it was removed the patient was out of bed with the wound practically healed, showed how rapid was the recovery. That gauze can be left for a long time within the cavity is well known, and has recently been excellently illustrated in a case reported by Dr. Chalmers Da Costa, in which a piece of gauze 8 by 1 inches was retained for thirteen days within the cavity of the skull.

Second, the results of removing the ganglion are, of course, not yet absolutely determined. The first case was operated on by Mr. Rose in 1891.\* Since then I have been able to collect 40 cases operated on by the two methods, and the result thus far is as follows: Of the 40 cases, 6 have died and 34 recovered. In none of them has there been any return thus far reported, excepting a partial return in one of the earlier cases of Mr. Rose. In no other case than his first one has there been the loss of an eye, and neither Dr. Tiffany in the 4 cases he has reported, nor I, took the least precaution for the protection of the eye, by preliminary temporary suturing of the lids. The results thus far seem to encourage us very much. If the removal of the ganglion should in time prove to be a final cure in cases of tic douloureux, my own opinion would be that it should be the *first* operation recommended for severe cases, provided that time and experience enable us to diminish the present relatively large mortality. If,

†In a later case at the Jefferson Hospital, Dr. Cryer kindly used this drill for me, and with great advantage.

\* British Medical Journal, 1892, i. 261.

however, the pain should return in any considerable proportion of the cases, then, as this is the final and terminal operation, I would certainly advise my patients hereafter to have repeated peripheral operations done, gradually approaching the centre; and the removal of the ganglion, should the pain return again and again, should be the *last* operation. In other words, if the operation of removal of the ganglion proves to be an unqualified success and its dangers are lessened, we should begin with that and not waste time with peripheral operations. If it is only, like the peripheral operations, a temporary relief, then we should begin at the periphery and work toward the ganglion by as slow steps as it is possible to take.

with the condition previous to the operation. He had no spontaneous pain in any part after the operation, and at the time of his discharge the aphasia had entirely disappeared as well as the mental depression.

In the regions supplied by the supra-orbital nerve, sensibility to touch was diminished as far as the vertex upward and forward to the median line of the face from the lobe of the ear and the lower border of the inferior maxilla. The mucous membrane of the lips and cheek on the right side, and the right side of the tongue were also partially anæsthetic. On the right side the sense of taste was entirely lost. The ocular and palpebral conjunctivæ were insensible to touch, but

TABLE OF OPERATIONS FOR REMOVAL OF GASSERIAN GANGLION.

Author	Reference	Recovered	Died	Total
Rose*	British Medical Journal, 1892, i, 261	5	..	5
Rose*	Lancet, 1892, ii, 953	1	1	2
D'Antona*	British Medical Journal, 1893, i, 81	1	..	1
Park*	Trans. Amer. Surg. Assoc., 1893, vol xi. 238	2	..	2
Andrews*	Journ. Amer. Med. Assoc. Feb. 18, 1893, 180	3	1	4
Krauset	Annals of Surgery, Sept. 1893, 362	5	..	5
Robert†	Proc. Philadelphia Co. Med. Soc., 1892, 490	1	..	1
Lanphear*	Pacific Medical Journal, 1892, xxxv, 647	1	..	1
Hartley†	Annals of Surgery, May, 1893, 511	1	..	1
Doyen*	Rev. de Chir., 1893, 391	1	..	1
Horsley†	British Medical Journal, 1891, ii, 1191	..	1	1
McBurney†	Annals of Surgery, 1893, i, 516, 519	2	..	2
Parkhill†	Medical News, Sept. 16, 1893, 319	1	..	1
Edw. Kerr*	Journ. Amer. Med. Assoc. Feb. 18, 1893, 181	1	..	1
Fernandez†	Siglo Med. Madrid, 1892, 804, 819; 1893, 4, 18, 36	..	1	1
Fowler†	Personal communication	1	1	2
Tiffany†	Annals of Surgery, Jan., 1894, 47	4	..	4
Flisney†	Johns Hopkins Bulletin, Oct., 1893	2	1	3
Novaro*	Jour. de Med., Chir. et Pharm., Bruxelles, Sept. 20, 1891	1	..	1
Keen and Mitchell†	The present case	1	..	1
		34	6	40

	Cases	Recovered	Died	Mortality per cent
* Rose's method	19	17	2	10.5
† Hartley's method	19	17	2	10.5
† Horsley's method	1	0	1	100.0
‡ Method unknown.	Reference furnished me by Dr. Hinsdale, which could not be verified.			

I append a table of all the operations I have been able to collect up to the present time.

## REMARKS BY DR. MITCHELL.

After the final operation on October 18th, it was not until the latter part of December, just before his discharge from the hospital, that the patient's mental condition improved so much that a careful examination of the areas of sensation could be made. There was no absolute anæsthesia, except between the margins of the flap of this operation. Sensation to touch was everywhere else preserved in some slight degree. Pain sense was but slightly impaired as compared

in the right infra-orbital region immediately about the scar of the operation upon the infra-orbital nerve, there was a small area which was hyperæsthetic.

When last seen, during the last week in December, I found that an area as large as a half dollar, with its center upon the outer third of the right eyebrow, covered a space which was hyperæsthetic to touch though not to pain, and this although he was unable to move voluntarily the muscles above the brow on this side.

Dr. K. has since returned to the hospital, reporting himself as continuing without any pain in the face, but one statement which he makes is certainly curious. During the cold weather when he goes out

he says that he feels as if he had two faces, one quite apart from the other; one of which, the left or normal side, felt the cold and the other did not.

When violent neuralgia marks out with lines of fire the course of superficial nerves, or when by operation we demonstrate the ramification of the tiny twigs to the skin and surface tissues, it is rather the rule than the exception to find some small anomaly in the distribution of the ultimate fibres, as compared with the topography described in the books. Physiological methods of tracing and mapping these nerves are needed, rather than those of the anatomist's dissecting table. In the case here described, the only anatomical peculiarity was the situation of a foramen more than an inch posterior to the mental foramen, giving exit to a nerve of some size, distributed thence on the tissues of the cheek. The foramen mentale was exceedingly small, and through it passed only a little twig, so slender as to make its discovery difficult and its recognition doubtful.

In another patient of mine upon whom Dr. Keen operated some years ago, a different difficulty was experienced in locating this opening. The patient, an elderly woman, had all her teeth removed. The gums and probably the alveolar processes had consequently atrophied, and the foramen was thus brought much nearer to the upper margin of the jaw than usual, and some search was needed before it could be found.

The regeneration that we so commonly find occurs in divided nerves when we do not want regeneration, followed the several nerve sections here, as in other cases. Such a frightful amount of pain teaches an opportune lesson of the desirability of deeper operations in the early course of trigeminal neuralgia. If the neuralgia persist, a neuritis almost inevitably follows, whether brought about by the same irritation which sets up the neuralgia, or, as I cannot but think often happens, set up by the neuralgia, the constant pain keeping the nerve over-stimulated and over-full of blood until it passes from active congestion into inflammation. A neuritis, however small, is a bad neighbor. We speak of ascending and of migratory neuritis; but every neuritis ascends and generally descends, too, though it may be only a small spread in either direction. But spread it will—and it is certainly as-

tonishing when we consider the close connection between the nerves of the face and the great centres of life in the brain, that we so rarely see brain disease result from this form of nerve-inflammation.

At the origin of these cases some form of peripheral irritation is often to be found, but by no means constantly. The teeth are usually blamed, and one seldom sees an old case in which they have not been more or less completely removed—because, if they had not caused pain, they might cause pain. The seat of distress is often in a tooth, but do we not always find the sensation of pain referred to the periphery of the affected nerve? I have seen at least one case in which relief of pain that had persisted in spite of palliative operation, resulted from the application of a properly fitting denture. No doubt the restoration of a natural amount of pressure upon the gums and alveoli had something to do with this. In Dr. K.'s case the original cause was in a tooth and destructive processes in the alveolus.

Besides the pain which accompanies these neuralgias, various other troubles may result from the peripheral irritation. One of my patients had had one or two attacks of lesser epilepsy a month, always at her menstrual periods, up to her fiftieth year, when they ceased with the menopause. When several years later, she began to have the trigeminal neuralgia, they returned, and became much more frequent, coinciding with the sharper paroxysms of pain. They disappeared with Dr. Keen's resection of the offending nerve, and have never recurred.

The second and third divisions of the trifacial nerve are much oftener subject to the attacks of tic than the first. It is impossible to assign any reasons other than suppositions for this. The functional necessities of the face and eye require that the nerves which supply them shall be sensitive and acutely perceptive in the highest degree. This gives them a certain susceptibility. Then the position, especially of the second and third divisions, exposes them peculiarly to sources of external hurt, such as irritation, or even infection, from decayed teeth, injury from cold, or from substances taken into the mouth, acting through the lingual branch as well as through the dental filaments.

The ganglion removed has not yet been minutely studied. It certainly would seem reasonable to expect to find in the



centre, after over stimulation continued for so long a period of years, some signs of this excess of action in the nerve cells.

Hodge, in the admirable papers published in 1889 and 1891, upon exhaustion of nerve centres has pointed out the microscopic changes we may expect to find in tired and exhausted cells. They are so distinct that when once acquaintance has been made with them it is not difficult to

say of two specimens, "This one came from an animal exhausted by muscular action; this one came from an animal in a healthy condition."

It has been supposed by some authors that the root of the malady lay in an atrophy of the ganglion; but were atrophy to be found, I would rather incline to regard it as a result than as the cause of the morbid condition of the nerve.

### PSEUDO-COXALGIA.\*

J. K. MITCHELL, M. D., PHILADELPHIA.

There is not much to be said about hysterical coxalgia apart from its differential diagnosis from true hip disease. The symptoms very closely resemble each other. Hip disease is not a very common form of appearance of hysterical disease of joints. The condition which most often presents itself is hysterical knee-joint disease. I have seen in some years past but two or three cases of simulated coxalgia.

The two differential points on which I should be inclined to lay the most stress are first, that under proper means of examination, even without anæsthesia, motion would be freer than if real disease existed, but this is by no means always true, since often in hysterical troubles a considerable amount of exudate is thrown out about the joint. Secondly, the condition of the local temperature is important, although not positive. If the temperature of a joint, suspected of hysterical disease, be increased and yet there be nothing in the general condition to point to inflammation, this would be an important matter; but it must be said, as was originally, I think, pointed out by Sir James Paget, that if the local temperature be higher at night than in the morning, the case is not one of acute inflammation, but of simulated disease most likely hysterical.

Sometimes there is swelling in these cases, but even if there were neither heat nor swelling, one could not by the absence of these signs alone be certain as to the purely nervous nature of the trouble. I think I should be more inclined to lay stress upon the appearance of the hysterical stigmata, such as tenderness in the spine, ovarian tenderness in females, photophobia, general hysterical manifestations, narrowing of the fields of vision, or changes in the color fields.

As to this later point, Dr. de Schweinitz and I, in a recent investigation, have found so few cases even in typical instances of major hysteria, where the color fields were altered, that it has made me doubt whether the statements, made by the French authors, as to the frequency of occurrence of this change in the eyes, are equally true for this country.

Besides this, in a majority of cases of hysterical disorder, we shall find uterine symptoms and marked tendency to constipation. Perhaps I might mention as a very interesting case of knee-joint disease, in which there was great difficulty in making a diagnosis, one which has already been reported by Dr. Weir Mitchell in his Lectures on Nervous Diseases. The late Dr. Sands, of New York, saw the case early when the joint was much enlarged and quite disabled. His opinion—and we all know it was one entitled to every respect—was that the swelling was entirely outside of the joint proper. Dr. Weir Mitchell saw the girl in consultation, and was also convinced that the case was a hysterical one. The patient, however, went abroad and, in Vienna, was seen by Dr. Billroth and by Dr. Nothnagel, who both were quite certain that the joint proper was diseased, and Billroth went so far as to say that if operation were done the cartilage would be found eroded. On the strength of this judgment, Dr. Sands, with considerable misgivings, opened the joint and found it absolutely normal as to its cartilaginous surface. The swelling which was present was altogether outside of the capsule, and consisted of a brawny thickening of the skin and sub-cutaneous tissues. He closed his wound carefully, and the enlargement, in the course of time, entirely disappeared under general treatment and the patient recovered perfect motion.

\*Read before Sec. Orthopedic Surgery, College of Physicians, Feb. 17, 1894.

## SARCOMATOUS OR OTHER TUMORS WHICH MAY, IN THE EARLY STAGES, BE CONFOUNDED WITH HIP DISEASE.\*

DeFOREST WILLARD, M. D., PHILADELPHIA.

Certain tumors originating in the region of the hip-joint, when accompanied by pain in their inception, may easily be mistaken for tubercular bone disease. I can recall but one or two such cases in children, but in adults I have seen a number which have been diagnosed as hip disease before their characteristics were distinct.

A physician who first sees such a case is always at a disadvantage in regard to diagnosis. In children, especially, the history will be very similar to that of tubercular hip-joint disease. A slight blow apparently arouses the disease; then follows pain with increasing limp, tenderness, slight fullness, thickening about the articulation, above or below it, slight limitation of motion in the direction opposite to the side upon which the mass originated; these are the symptoms which would naturally lead one to infer that the more common disease of tubercular osteitis exists rather than the rarer one of sarcoma. An experienced orthopedic surgeon, however, will at once recognize that this partial limitation of motion is frequently found in exceptional cases of tubercular lesion.

Moreover, pain, which increases with the growth of a sarcomatous tumor, is a very constant symptom in the tubercular form; consequently, as I have said, any man is excusable for a mistaken diagnosis in the first few weeks of sarcomatous disease. As the growth proceeds, it is apt to become more localized, that is, its projection is a firm hardened mass in a certain direction, usually anteriorly; while in the tubercular variety, the thickening is more diffused over the region of the joint.

The tumor may or may not be nodulated. Restriction of motion is positive in one direction, usually extension, while flexion is somewhat interfered with by the size of the growth. Tenderness is also limited to a small area, smaller than in the tubercular variety, pain but seldom extends down the inside of the thigh towards the knee.

Flexion is usually present to a moderate degree. Abduction or adduction are rarely present. The buttock may be flattened and the ilio-femoral crease shortened as in tubercular hip disease. Instead of atrophy of the limb there is usually swelling or oedema.

During the latter stage the diagnosis is easy. The size, position and character of the swelling is sufficient to mark its nature. Pain, especially in adult cases, does not increase in proportion to the extent of the disease. In one case which I recall, the man suffered exceedingly for two months while the tumor was small, but was almost entirely free from pain during the remainder of its progress (over a year) when the tumor attained enormous proportions. In his case, while the greater portion of the tumor was hard, yet there was numerous cysts and fluctuating points the tapping of which might have been considered for the relief of pain had not the symptoms ceased to be violent.

In one or two other cases which I recall, the cessation of pain, as the disease progressed, was very marked. In one case, already alluded to, the tumor apparently sprung from the periosteum of the neck of the femur, possibly from the bone above the articulation. It had advanced too far before it was noticed, for any operative procedures to give relief, and death occurred from exhaustion. I did not see the case during the early stage, but the history was somewhat similar to that of joint disease; a slight injury, pain after a long walk or after standing, increased shortening of the limb, and gradual interference with the function.

I have a case now under my care which presents very similar symptoms, and yet I believe it to be an early stage of tubercular hip disease in the adult; another case, which is very similar, I believe to be rheumatoid arthritis, and yet I do not accuse myself of ignorance in being unable to positively fix the diagnosis at the first visit. Time alone can solve the problem.

I have a young man under treatment whose difficulty I have recorded tubercu-

\*Read before Sec. Orthopedic Surgery, College of Physicians, Feb. 17, 1894.

lar, and yet I have a strong suspicion, on account of the local character of the projection, that it is sarcomatous disease in process of development.

Another case is that of a man forty-five years of age whom I saw in consultation. I found no difficulty in diagnosing sarcoma, although it had been treated for many months, by experienced surgeons, for tubercular trouble. It is no credit to a surgeon who is called in at the late stage to decide as to the character of the tumor.

I saw, still another man past sixty, a consultation case, in whom the pain had been atrocious, but which diminished gradually after the compact tissue of the ilium had yielded sufficiently to permit easy expansion. He had been treated also for many months for hip disease.

I saw to-day, a case of possible malignant disease, in a man thirty years of age, but as there was a history of a year of pain which was characterized as starting at night, and as there was a large but evenly distributed induration about the hip, marked with flexion and abduction, I am strongly inclined to consider it as a case of ordinary hip disease rather than that of commencing tumor.

In another instance where I was called in the country to see a case of hip disease which had existed for many months, a hardened nodulous tumor arose distinctly from the region in front of the trochanter and had attained the size of a child's head. The early history had misled the attending physician, and as is not infrequently the case, had biased his opinion even when decided sarcomatous appearances were marked later.

Every physician frequently finds himself placed at a disadvantage. Relying upon his first diagnosis, and perhaps relaxing his vigilance, or perhaps failing to re-examine the case for some weeks, he will find, during a more thorough examination, conditions entirely different from those which existed a month previous. Such situations are unpleasant, and are nearly always due to insufficient care; not infrequently to insufficient exposure of the part. I am daily more and more convinced that a large proportion of errors in diagnosis would be avoided if the naked body could be observed and a comparison of the two sides noted.

Sarcomas in this region are usually very malignant in their character. Their

growth is slow until rupture takes place, after which rapid dissemination is the rule, with quite possible metastases. The cysts are apparently due to the liquidation of the tumor elements, or to extravasation of blood and serum. Tapping of the cysts is inadvisable except when the pain becomes very great, as protrusion of the mass with hemorrhage follows. In some cases the great vascularity of the tumor with its pulsation may simulate aneurism, especially the central round cell sarcoma, the medullary or hematoid cancers.

Few of these tumors are suspected from the beginning and only occasionally is it possible to recognize them early. In order to do this the entire group of symptoms must be surveyed, not merely one particular symptom. In the majority of cases it will be found that although one or two, or perhaps half a dozen symptoms indicate tubercular trouble, yet one or more important symptoms are absent. It requires, therefore, careful sifting of all the evidence, and close observation, as a safe guard against error.

Sarcoma, as a rule, especially in children, is of rapid growth and ordinarily accompanied by severe pain in the early stage. In my experience, in adults, it springs frequently from the ilium rather than from the femur, and these cases are incapable of being benefited by operative procedures. Sarcoma is much more common than carcinoma in this region. The central growths are ordinarily of the giant cell variety.

Suppuration, in my experience, is rare; in fact, I do not recall an instance in which it has occurred. The patient usually dies from exhaustion, or from systemic infection, or a blood vessel transference of the disease or some other organ, even before rupture of the skin and hemorrhagic protrusion of the contents take place. When suppuration does occur, I believe that it usually arises from other inflammatory elements—probably traumatic.

THE corset is a waist basket. It is also a waste basket in wasting health, vigor and vitality.

#### Something Easy.

Waiter—"De usual steak, sah?"

Regular Customer—"No; I am tired to-night. Bring me a plate of hash."—*Indianapolis Journal*.

## TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.\*

## INFLUENZA, BRONCHITIS AND BRONCHOPNEUMONIA.

In *Revista Clinica Terapeutica* (No. 12, 1893) the sulphate of codeine is recommended, in the treatment of the gripe, bronchitis and broncho-pneumonia, in the following formula:

**R** Salicylate of Cinchonidine.  
Hydrate of Terpene,..... 55 18-30 (grs. ijss-v).  
Sulphate of Codeine,.... 5-75 mgms. (1-13 to 1 1-16 grs. gms).

Sufficient for one capsule. Make twenty such capsule. One every 2-4 hours.

## ACETANILID AND DOVER'S POWDER IN GRIPPE.

Dr. E. Graetzer (*Wiener Medizinische Presse*, No. 6, 1894), in the treatment of the gripe recommends a combination of Dover's powder and acetanilid which he has employed, with the best results:

**R** Acetanilid..... 25 cgms. (grs. iv).  
Dover's Powder..... 15 cgm. (grs. ijss).  
One powder three times a day.

## PERMANGANATE OF POTASH IN ACUTE POISONING BY PHOSPHORUS.

Dr. Adolf Kelemen (*Pester Med. Chirurgische Presse*, No. 3, 1894) in support of the efficacy the permanganate of potash as an antidote in poisoning by phosphorus, reports the following case: A peasant woman of fifty-four years, dissolved the heads of four packages of matches in water and drank the solution, at eleven o'clock in the morning. The writer was called at half past two in the afternoon, when he found her in bed restless and continuously vomiting. Her gastric region was painful, her face pale, her pulse rapid and full. He had brought with him two quarts of a 1-per cent. solution of the permanganate which he had her drink by the glass full every three to four minutes. Within two hours she drank over a quart of the solution and vomited twice. He then left the patient, with instructions to drink the remainder. The next day she complained of violent pains in the stomach and had vomited three times. He ordered another quart of the solution to be drunk. For three days the gastric pains continued

and coagulated blood was found in the vomit. As a beverage she received albumen water. From the fourth day the pains decreased in intensity, the vomiting did not reappear and her general condition so improved that she could be regarded as cured. The writer has observed several cases of poisoning by phosphorus, yet this is the only recovery that he has known. As all others ended fatally he can only ascribe the result to the permanganate.

## MASSAGE IN INTESTINAL INCARCERATION IN CHILDREN.

Dr. Maiss (*La Semaine Medicale*, No. 72, 1893), treated a child of nine months who after an attack of indigestion was seized with symptoms of obstruction. A sausage-like tumor was found in the region of the descending colon which extended into the left iliac fossa. In spite of large doses of opium the condition of the patient became worse and a laparotomy seemed indicated, but before operating he tried massage. With the pelvis elevated the right hand was placed over the iliac tumor, thus fixing it, while with the left hand the lumbar region was compressed. The tumor was then pushed upwards towards the diaphragm and immobilized and effleurage done from left to right. After a few such movements, with deep pressure, the tumor together with all the symptoms of occlusion, disappeared. Dr. Barder, in the same journal, records two other cases. The first was a child fifteen days of age, where opium and intestinal irrigation were without effect. By bimanual examination he was able to make out a cylindrical body, seven to eight cms. in length, which lay obliquely in the left hypochondrium; invagination of the colon in the ileum. A few frictions with the right hand, from left to right, produced a marked relief. A second and more energetic massage caused the tumor and the symptoms to disappear. The third case was that of a girl of eighteen months, who had suffered for several days from diarrhoea and who was seized with symptoms of incarceration after an attack of coughing. In

\*In charge of the translator, F. H. Pritchard, A. M., M. D.



the left iliac fossa a sausage-shaped swelling could be outlined through the abdominal wall. A few seances of massage, with the little finger of the left hand in the rectum and with the right hand pressing on the tumor, gradually caused it to disappear.

#### QUININE IN INFLUENZA.

Dr. Graesser (*Wiener Medizinische Presse*, No. 3, 1894), has employed quinine in the epidemic of 1889-90, in the Poliklinik at Bonn, and claims that the patients thus treated suffered less from after-effects of the disease. Only three reappeared for treatment the second time, while of those who received other remedies over half came the second or third time. The depression and feeling of tiredness were of much shorter duration than those under other treatments. It was also employed prophylactically. In Bonn the soldiers of a regiment received seven and a half grains of the sulphate in half an ounce of whiskey every day for twenty-two days. Though some fell sick, fewer were attacked than in other regiments or in another in the same garrison. From his experiments he regards quinine as a specific in influenza.

#### PETROLEUM IN CANCER AND VAGINITIS.

Dr. Desprès (*Centralblatt für Gynäkologie*, No. 48, 1893), recommends ordinary refined coal oil in the treatment of cancer and vaginitis. In ordinary inoperable carcinoma of the uterus he injects it into the tumor and applies it on tampons in the vagina or uses it in irrigations. Injected into abscesses it causes healing to take place, removes the disagreeable odor of disintegrating carcinomata, especially of the uterus, causes the gangrenous surfaces to be cast off and the ulcerations to become dry. In vaginitis he has also employed it with success as injections and claims that after three daily injections of four to five ounces of the oil, a cure will be obtained in six days. Petroleum has the advantage of easily diffusing itself, deodorizing and disinfecting and yet not irritating the mucous membranes. If applied to an already inflamed mucous membrane it has caused vesicles to form. The patients did not complain of the odor nor was their general health affected.

#### QUININE IN WHOOPING COUGH.

Dr. P. Baron (*Wiener Medizinische Presse*, No. 3, 1894), has tried quinine in fifty cases of whooping cough and is well satisfied with the results. In a few of the children a favorable result was observed at once, especially on the second to third day. But in the majority the results were varying for several days, as they were inclined to vomit and unequal quantities of the drug were absorbed. The stage when the drug is administered has quite an influence. From the fifth to the sixth day a decided improvement as to the number and severity of the attacks may be relied upon. When improvement has once set in it still will continue even if the remedy be given in smaller doses. On an average three weeks were required to effect a cure; in some cases the action is actually abortive. No relapses. It is especially valuable in cases accompanied by acute pulmonary affections. The single dose is one-fifth of a grain per month and one and a half grain per year, of the child's age, three times a day. It is best given in the morning at six, in the afternoon at two, and in the evening at ten o'clock. More than three doses per diem, or six grains, for children over four years is not necessary. If improvement has set in distinctly then do not give more than two daily doses, then decrease it gradually and after nearly complete recovery, let them take a dose in the evening. If the appetite is deficient prescribe hydrochloric acid.

#### NEURALGIC DYSMENORRHEA.

In the *Rivista Clinica e Terapeutica*, No. 12, 1893, the following formula is spoken highly of in neuralgic dysmenorrhœa:

**R** Extract opium.....10 cgrms (grs jss)  
 Extract belladonna.....10 cgrms (grs. jss)  
 Sulphate of quinine.....1½ gms (grs. xxiijss)

Sufficient for twenty-five pills. One every three hours.

#### SACCHARATED SOLUTION OF IRON AND MANGANESE.

In the *Union Médicale*, No. 49, 1893, the following formula is presented:

**R** Saccharated oxide of iron.....200 gms (3vjss)  
 Distilled water.....700 gms (3xxijss)  
 Crystallized chloride of manganese 3.7 gms (grs. xiv).

Dissolve the iron in the other two constituents, then add:

Distilled water.....	15 gms (3iv)
Sol. citrate of ammonia.....	25 gms (3vj)
Alcohol.....	50 gms (3jss)
Tint. orange peel.....	3 gms (gtts. xiv)
Tinct. vanilla.....	1 gm (gtts. xv)
Acetic ether.....	gts. v.

#### ICHTHYOL IN ACUTE OTITIS MEDIA.

Dr. Solt (*Gazetta Degli Ospitali*, No. 150, 1893), on account of the good results which have been obtained in metritis with ichthyol, has tried it in acute otitis media. He advises the following formula:

<b>R</b> Ichthyol.....	1 gm (grs. xv)
Glycerine.....	
Distilled water, aa.....	7½ gms (3ij)

Drop a few drops of this mixture into the meatus three times a day.

He claims that it exercises a very favorable result in acute otitis media. The pains cease rapidly and the inflammatory symptoms gradually disappear.

#### CASTOR OIL ADMINISTERED AGREEABLY.

In the *Gazette Degli Ospitali*, No. 150, 1893, it is asserted that if one shake a mixture of castor oil in warm milk, in a bottle, an agreeable emulsion is obtained. The disagreeable odor and taste are thereby masked.

#### TREATMENT OF HEADACHE IN CHLOROTIC PATIENTS.

Dr. Albert Robin (*Gazette des Hopitaux*, No. 10, 1894), advises the following formulæ in the treatment of the headache of chlorotic subjects:

<b>R</b> Powdered paullinia.....	20 cgms. (grs. iij).
Extract of cannabis indica.....	1 cgm. (gr. jss).

Sufficient for one pill. Three pills a day.

<b>R</b> Antipyrine.....	50 cgms. (grs. vijss).
Mur. cocaine.....	1 " (grs. jss).
Caffeine.....	1 " (grs. jss).
Bromide ammonia.....	50 " (grs. vijss).
Iodide ammonia.....	50 " (grs. vijss).

Sufficient for one powder. One per diem.

<b>R</b> Phenacetine.....	25-50 cgms. (grs. iv-vijss).
Rxalgine.....	10-15-25 " (grs. jss-ijss-iv).

Sufficient for one powder. Two per diem.

Ferrous preparations may be tried, but the results are variable. Menthol externally may be of service.

#### HYDRASTININE IN EPILEPSY.

Dr. Kisselew (*Le Mercredi Medical*, No. 51, 1893) on account of the anti-

convulsive action which he has observed hydrastinine to exercise on animals, has tried it in epilepsy. It was administered internally in a watery solution, in a dose of one to two cgms. (1-6—1-4 gr.) and five doses, per diem. In all he gave it to four patients. In two the result was negative, while in the other two, after two or three weeks of treatment, there was a remarkable diminution, both in the intensity and frequency of the attacks. No inconvenience was observed from its use.

MANY people cannot understand why the small pox at present continues to crop up in new localities, and seems unconquerable. One of the reasons is to be found in the ignorance and turpitude of the tenement-house population, especially among the recently-arrived Italians. One of the special inspectors appointed by Dr. Doty to look out for suspicious cases, was directed by a policeman to a tenement in Mott street, on February 25th. The inspector found the doors to the room on the top floor locked and barred. Threats to arrest the inmates had no effect, and finally the doors were broken in. A search of the rooms revealed no sick person, but just as the doctor was leaving he heard some one sneeze. The sneeze seemed to come from a big trunk in the corner, and lifting the lid, he found an Italian boy beneath some bedding. The boy was covered with the eruption of small pox, and had been sick five days, and had no medical attendance. On the floor below, where also the doors had to be broken in, there were two children hidden away. One had been attacked twenty days ago, and was now recovering; the other, a girl, four years old, was very ill of the disease. This tenement shelters twenty-five families, of Irish and Chinese, and, of course, a corps of officers was at once set to work searching all the tenements in the neighborhood and vaccinating the occupants. In a tenement in West thirty-sixth street, no less than five cases were found, and the officials were not resisted, it was found that though the two families affected many other persons had been exposed. It is plain that nothing but the constant vigilance and actual vaccinating work of Dr. Doty's men saved us from a wide diffusion of the disease.—(Ind.)

# THE MEDICAL AND SURGICAL REPORTER

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SATURDAY, MARCH 24, 1894.

## EDITORIAL.

### TREATING PULMONARY TUBERCULOSIS WITH TUBERCULIN.

In a paper read before the Climatological Society, last May, by Dr. Karl von Ruck, Koch's tuberculin was shown to possess curative properties greater than has recently been attributed to it. Twenty-five cases that had been treated with it were reported. These were divided into three classes: *Class A*, included three patients, "who had one or both upper lobes involved, but without destructive changes, the general health of these patients being comparatively good." *Class B*. Patients "with more extensive disease or moderate destructive processes, but still in a fair physical condition." *Class C*. Cases "still further advanced in local disease, with considerable constitutional impairment, but still in a condition justifying some hope of improvement." In class *A*, five patients were treated and all recovered. In class *B*, seven cases were treated, of which six recovered and one was improved. There were thirteen belonging to class *C*, of which seven died and six were improved and still living.

Much of this success is attributed to the method of administering the tuberculin. The initial dose used by von Ruck was 1-20 milligram and the quantity was gradually increased by tenths of a milligram until one milligram was given. Then the increase was by fifths up to two milligrams; then by halves up to ten; by doses of two and a half milligrams up to twenty; and thereafter by doses of five milligrams at a time. Periods were observed when for weeks together no local or general reaction was observed, while the improvement of the patient progressed favorably; and whenever a point had been reached where this improvement was radical and active symptoms had entirely subsided, the administration ceased, allowing an intermission of from two weeks to a month. If no relapse had occurred in this time, if every symptom and indication was favorable, the patient was kept under observation. If the result was not satisfactory a repetition of the treatment was necessary.

In the second course the initial dose was

1-10 milligram, but increased after each dose so long as no local reaction occurred.

These results are encouraging, but the fact should be borne constantly in mind that it is in the early stages of the disease that the greatest benefit was received. The practical importance of this is the necessity for early diagnosis, a fact well known to all physicians, but often neglected until the disease has advanced so

far that the diagnosis is evident from the advanced lesions produced. Again the fact should not be overlooked that von Ruck had the benefit of excellent climate and the perfect control of his patients which he himself admits were valuable adjuncts.

However, his results are encouraging and the evidence quite conclusive that much benefit was obtained by the use of tuberculin.

### STERILIZING MILK AT A TEMPERATURE OF 75° C.

Freeman (*Med. Rec.*, June 10, 1893), has contributed an article of much interest on the sterilization of milk at a temperature of 75° C. (167° F.). This is known as *pasteurization* of milk.

The method formerly employed to sterilize milk was to heat it to a temperature of 100° C. (212° F.)—or to the boiling point. This process was found to produce many changes in the milk which renders it less digestible. The casein is rendered less coagulable by rennet, and is acted on slowly and imperfectly by pepsin and pancreatin. Milk sugar is destroyed.

Pasteurization, however, furnishes a food which is practically sterile during the ensuing twenty-four to forty-eight hours; a food on which infants seem to thrive, and which has undergone practically no modification from heat. Milk prepared in this way is not intended for keeping several days but should be prepared daily.

The author had repeated many of the experiments to determine the thermal death point of certain pathogenic bacteria which may find their way into milk. His conclusions are as follows:

1. "Pasteurization of milk at about 75° C. affords a safe guard against deleterious effects of any bacteria which it may contain, without interfering with its nutritive qualities.

2. "Pasteurization at about 75° C. (167° F.) destroys efficiently the germs of cholera, typhoid fever, diphtheria, and tuberculosis, as well as the streptococcus pyogenes, the staphylococcus pyogenes aureus, and the bacillus coli communis."

3. "Pasteurization at about 75° C. does not modify the size of the curd formed when milk is subjected to the action of the gastric juice."

4. "Milk after pasteurization is best cooled in a water bath."

5. "Pasteurization at about 75° C., may be used after peptonizing to stop the action of the ferment."

THE crusade of the State Boards of Health against quacks, brings to light some queer characters, and presents a melancholy spectacle of dupes who pour money into the pockets of these unprincipled harpies. At one of the meetings of the State Medical Society of Missouri, an account was given of an old impostor in the northern part of the State who claimed to have wrought miracles of healing "with only three remedies," all from a certain root. *Highbalorum* was obtained by peeling the root upward, and was a certain emetic. *Lobobalorum* was obtained by peeling the same root downward, and was a sure cathartic; and *Hilobustem*, by peeling the root around, was a rank poison and would carry everything before it was only to be used when the others had failed.—*N. Y. Med.*



### PROTOZOA AND CARCINOMA.

There is probably no subject in pathology over which there is more earnest controversy than the etiology of cancer. That cancer is due to the presence of a protozoan, has been positively asserted by certain investigators, while others maintain that it is not of parasitic origin.

Adler (*Amer. Jour. Med. Sci.* Jan. 1894.) gives the results of his study of cancer, in which the adherents of the protozoan theory can not find pleasure. He has studied the subject for over three years, has used many methods of investigation, and has examined over 60 cancers

from different parts of the body.

After a careful discussion of the subject he draws the following conclusions:

"The existence of parasitic protozoa in cancer is probable, though the greater part of what has hitherto been described as parasitic is certainly not so. No constant or in any way specific organism has as yet been demonstrated beyond possibilities of doubt. At present no facts, histological or otherwise, compel the assumption of a parasitic origin of carcinoma, while there are very strong and valid arguments against such assumption."

### ABSTRACTS.

#### TWO CASES OF HERNIA OF THE FALLOPIAN TUBE.

Dr. Morton reports a case of a woman, forty-six years of age, who sought advice at the out-patient department of the Royal Surrey County Hospital, on account of a swelling in the right groin. She had had a swelling there constantly for two years, and it had suddenly become larger five days before she attended the hospital. There had been no action of the bowel for five days. The swelling was tender to the touch and gave impression of an inflamed gland softening in the centre.

A simple enema was administered, and produced a considerable evacuation. Four days later an incision was made over the swelling through tissues which were of almost cartilaginous density. This exposed a rounded, grey, translucent mass, which looked almost like the colon, but was in reality the thickened sac. On opening the sac, a small quantity of coffee-colored fluid escaped. The sac contained some omentum and an irregular, varicose-looking mass, attached to one end of which were some congested papillary projections. These latter proved to be the Fallopian tube and its fimbriated extremity. The tube and omentum were returned and the sac was ligatured and cut away. The wound healed by first intention.

Case 2.—A woman was admitted to the

Royal Surrey County Hospital suffering from a strangulated right femoral hernia, which had been down for five weeks. The symptoms of strangulation were of a fortnight's duration. A simple enema produced a copious evacuation, and this was followed by a copious natural evacuation some hours later. Herniotomy was performed and the sac was found to contain gangrenous omentum and gangrenous ruptured bowel. The peritoneal cavity contained a large amount of faecal matter apparently mixed with pus.

The gangrenous omentum was removed, and an artificial anus made, but the patient died from shock twelve hours later.

At the post-mortem examination the bowel was found to be ruptured about eighteen inches above the ileo-caecal valve. The omentum, small intestine, and caecum were all much matted together, and glued to the surface of the mass so formed was the end of the right Fallopian tube, which was gangrenous to the extent of about half an inch, having evidently been caught in the constricting band. The vermiform appendix was apparently healthy, although the finding of an orange pip in the peritoneal cavity had given rise to a suspicion that the appendix might also be involved.

—*The Lancet*, 1894.

## SOCIETY REPORTS.

### SECTION ON ORTHOPEDIC SURGERY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

February 17, 1894.

[Stenographically Reported by C. C. Mapes, M. D.]

DR. DEFOREST Willard opened the meeting by reading a paper upon "Sarcomatous or other tumors, which may in their early stages be confounded with hip disease." (See page 424).

#### DISCUSSION.

DR. G. G. DAVIS: I do not remember having seen a case of sarcoma of the hip, but I recall two cases of tubercular disease in one of which an enlargement occurred above the trochanter and was supposed to be sarcomatous. It was operated upon and proved to be a collection of pus which had originated within the pelvis and come out of the greater sacro-sciatic notch. The swelling was the size of a small egg and being in that position and covered with muscle, it was difficult to be positive that fluctuation was present. I have seen, also, another case in which pus came from the same opening. The collection of pus arose from carious bone and worked its way downward and outward through the notch, and gave rise to the suspicion of tumor. A collection of pus so close to the hip joint might very readily give rise to a diagnosis of hip joint disease.

DR. T. S. K. MORTON: I have nothing to add to the presence of growths about the hip joint, but in thinking this matter over I recall a case of carcinoma of one mammae, in a woman about forty years of age, which I saw several years ago. Some eight to ten months afterward she tripped when walking, and had a very slight fall to the floor which resulted in fracture of the neck of the thigh bone, and she died from shock. At the post-mortem was found metastasis of soft carcinoma throughout the body. The point of interest was the great destruction of the neck of the femur; it was almost replaced by soft carcinoma which left a thin shell of bone, so thin, that slight traumatism was sufficient to break it.

DR. BENJAMIN LEE: I have nothing to add to the history of such cases; judging from my own experience I should presume them to be extremely rare in comparison with tubercular disease of the hip joint. In regard to diagnosis I am of the same opinion as Dr. Willard. I should not expect these affections to have the same history as true hip joint disease; that is, to say, commenc-

ing with lengthening and eversion and going on to shortening and inversion. I presume that before such change could take place, the tumor would declare itself by its own characteristics. Another point of difference would be the absence of the starting pains, so characteristic of hip disease. One remark made by the author of the paper impressed me very much; and that was that in making his examination of these cases he had taken the pains to strip the patient so that the two sides could be compared, on this point I think we cannot insist on too strongly. I believe that the reason that the family physician often makes a mistake, and has to call upon an orthopedic surgeon for counsel is simply because he has neglected to make an examination, as Dr. Willard suggests, with the naked body before him. This should always be done, especially in suspected lateral curvature or hip disease; I consider it of the greatest importance.

DR. DEFOREST WILLARD: I have been called to the country twice this week in consultation, and in each case the physician could have made the diagnosis as well as I, if he had simply stripped his patient.

I remember a peculiar case on which Dr. Agnew operated for sarcoma of the breast. In twelve or fifteen months there was a return of the disease in numerous regions of the body. Both humeri were broken by very slight movement; one finger was snapped by being caught in the sheet of the bed and the other while being laid across her breast. Absolute union took place without any difficulty. The disease was progressive and she died a few months afterward. At the post-mortem was found a good callus, and no sarcomatous disease at the line of the fracture. It is interesting that in spite of the fragility of the bones, good union had taken place.

DR. F. SAVARY PEARCE: I recall no cases in the Orthopedic Hospital during my residency, of tumor of the hip, but I remember one of the upper middle third of the femur; it developed rapidly and had a fatal termination. The tumor was diagnosed sarcoma and was probably secondary to a malignant breast growth, removed some months previous. The woman was past middle life.

DR. G. G. DAVIS: I would like to ask Dr. Willard if he regards the condition as malignant disease of the humeri, or simply one of atrophy caused by the general dyscrasia. Cases of fracture occurring in malignant—particularly sarcomatous—diseases are not uncommon, but I would like to ask if this particular case was locally sarcomatous.

DR. DEFOREST WILLARD: I do not think there was sarcoma at the particular point which gave way. I believe the bones were fragile from the general condition, although there were probably twenty sarcomatous foci in other regions of the body.

There is no difficulty in diagnosing these cases in the later stages; it is in their beginning that a differential diagnosis is difficult to establish. I never saw starting pains in this condition. The pain is continuous and very severe with atrocious exacerbations. Starting pains make a very good diagnostic point.

DR. F. SAVARY PEARCE: A differential diagnosis must be made between malignant and simply ulcerated growths, and this is sometimes difficult. I heard of a case operated upon by Dr. Agnew who was misled by a large fatty tumor about the hip. The growth had ulcerated on the surface and a section was made for microscopical examination. It was reported malignant and the limb was amputated with a fatal result. Ulceration had occurred over the growth which was a simple lipoma as stated. In this case the microscopist was at fault, not the operator.

#### "SARCOMA OF THE THIGH."

Presented by Dr. J. T. Rugh by invitation.

The case is one belonging to the Orthopedic Department of Jefferson Medical College Hospital, under the care of Prof. H. Augustus Wilson, and is extremely rare and interesting.

While there is no contra-indication to the development of sarcoma in hip joint disease, yet such a condition has seldom, if, indeed, ever been reported.

The history is as follows: W. W., aet. 19 years, born in Austria, and living in this country for the past two years. Family history good, personal history good until 15 years of age, when he fell striking heavily upon his right hip. The parts were quite sore for a few days but no special attention was given to the injury. In a few weeks pain and soreness developed and difficulty in walking was soon experienced.

These symptoms continued for several months, with occasional intermissions until the tenderness became extreme and enlargement of the part was observed; which gradually increased until one year from the receipt of the fall, an abscess ruptured on the pos-

terior surface of the thigh and discharged very freely. Relief followed but the sinus remained patulous and in the next two years, or until January 31st, 1893, four new ones were formed. At this time he first came to the clinic and was admitted to the ward of the Hospital. Another abscess formed and an operation was deemed necessary. The bony involvement was evidently very great. On February 2nd, 1893, Prof. Wilson opened the part freely on the external surface just over the large trochanter and removed considerable dead bone. He also evacuated several pockets of pus. The acetabulum was extensively involved but was not disturbed. Drainage was obtained by rubber tubes, the wound closed, and the usual dressings applied. Tubes removed in three days and parts dressed twice a day while in the ward. He was discharged on April 6th., 1893, very much improved in weight and strength. He has been dressed two or three times a week ever since.

In the latter part of December, 1893, a slight swelling appeared about  $1\frac{1}{2}$  inches below Poupart's ligament, extending downward and inward across the large vessels. This gradually increased and by the end of the first week in January, 1894, the circulation became hindered because of the situation and enlargement of the tumor. A week later fluctuation could be detected at several points but it lacked the elastic and expansive feel of the true abscess, and was more like a trans-muscular wave; but on account of the pre-existing osteitis, the rapidity of development and fluctuation, an abscess was diagnosed by all who examined it. There were also enlarged veins; oedema (slight over the tumor but marked below it); no elevation of the temperature, no pain, no soreness, and no heat or redness.

On January 27th., 1894, Dr. Mann and I opened it in two places but found no pus. The finger introduced into the wound detected very soft, friable, and easily detached tissue. Hemorrhage was very profuse. Some separated pieces were examined and thought to be sarcomatous, both from appearance and feel. Closure of the wound stopped the hemorrhage and dressings were applied.

Sections of the tumor were made and examined by Prof. Coplin and Dr. Kyle but neither would say positively that it was sarcoma, yet both agreed that it had more the characteristics of such than of inflammatory tissue which it resembled.

The clinical history is plainly that of sarcoma for the list of local and constitutional symptoms entailed in the production of so extensive an inflammatory exudate are all absent. On Feb. 13th, when I removed the dressings, a large fungating mass existed at one of the incisions from which quite a

stream of blood flowed. The mass was about  $1\frac{1}{2}$  inches in diameter and was raised about  $\frac{1}{2}$  inch above the skin. The origin is very doubtful as there are many structures from which it might arise, but the probability is that it is of bony origin though it may be from the connective tissue of some old sinus, and caused by some irritative impression of the tubercular ostitis.

Removal of the growth would be impossible because of its size and situation. Amputation is also negated by the widespread tubercular infiltration which exists. Comfort only can be offered though not insured.

(The patient was then brought in and examined by all present. Sections of the tumor were also shown with the microscope.)

#### DISCUSSION.

DR. J. K. YOUNG: This case should not be allowed to pass without some discussion, yet there is very little to be said. The opinion given by the pathologists is one that we often hear. My experience with pathologists has been very unsatisfactory, and I prefer to rely upon the clinical history and appearance. My opinion is that very little can be told by pathologists as to the character of a specimen until the death of the patient or the entire tumor is removed. This was particularly noticeable in a recent case in which the pathologists gave a report that it was malignant, but which was reversed upon more thorough examination. There are only two symptoms in the present case which point to its being benign. The growth appears to have occurred in the cicatrix of one of the sinuses, in the interior portion of a groin. It will probably be found that the femur had been the starting point. Fungoid tumors about the sinus are not uncommon and they have the characteristic appearance spoken of by Paget. The position of this sinus and the character of the growth would indicate the femur as the part involved. If in this case the tumor be benign, the bleeding and the oedema might be due to pressure upon the femoral vein. The great size would indicate a mass of granulated tissue in the capsule.

DR. G. G. DAVIS: This condition interests me because if it is sarcomatous it shows the co-existence of two diseases in the same neighborhood, and both of them marked ones. The sinuses are not all closed; there are four open ones, all discharging, and there must be active disease going on somewhere. The presence of active bone disease and active malignant disease in the same vicinity, both pursuing a marked course, is, I think, unlikely. Should it be the two diseases, it is most remarkable. I should not be willing to make a diagnosis without

some hesitancy, and yet I would not be surprised at a pathologist making a diagnosis of malignant disease from the granulations surrounding the opening. I think there is at least some room for doubt as to the affection being malignant.

Dr. Mitchell has just made a suggestion as to the original disease having been malignant instead of tuberculous. I do not think this can be the case as the tubercular disease has existed for three years and pursued a steady course of clinical bone disease, and we know that sarcoma has no tendency to suppuration, and therefore I do not think that the primary disease was sarcomatous.

DR. DEFOREST WILLARD: The possibility of the disease having been sarcomatous from the first also occurred to me, but the clinical history is so characteristic of bone disease that the diagnosis seems very clear. I should rate it a tubercular ostitis. But its present condition I should not hesitate, however, to call a sarcomatous growth. It is an unusual case, I have never seen one like it. It is probably a sarcomatous disease which has become engrafted upon the cicatrix. There is nothing incompatible in the co-existence of the two diseases; it is altogether possible. In this case I do not think we can take any exception to the diagnosis made. The course will probably be rapid from this time.

DR. T. J. RUGH: There is one point to which I should like to call the attention of the section and that is in regard to the microscopical examination. The part for section was taken from the centre of the tumor itself. The tumor had not been opened until it had been opened by the knife. The point upon which the pathologists were in doubt was the condition of the blood vessels, which are thoroughly characteristic in inflammatory tumors, that is, the walls are thickened and enlarged, while in sarcomatous growths the blood vessels have no walls. In this specimen they found, in some parts, thickened walls; in other parts, none. That is my reason for the statement that they would not affirm or deny in favor of sarcoma.

DR. J. K. MITCHELL: It seems to me that the question of tuberculosis might readily be disposed of by the microscope or by cultivation.

DR. J. T. RUGH: I did not tell the pathologists from what part of the body the specimen was taken, nor anything of the clinical history, and their reports were based entirely upon the microscopical examination.

DR. SAVARY PEARCE: The talk seems to have drifted into the difference between *macroscopic* tubercular and sarcomatous conditions. *Microscopically* ulceration and sarcoma are allied. In October last I removed a breast from a case of my father's which had all



the appearance of malignant disease and was fungoid in character. The patient was a woman fifty-two years of age. There was no enlargement of the lymphatic glands. The pathologist who examined the specimen thought it sarcomatous; my father supposed it to be carcinomatous. At a meeting of the Pathological Society, a section was shown to Prof. Guiteras, who decided it to be intercanalicular-fibroma. The wound healed by first intention. The woman is now well. I speak of this because the difference in opinion of pathologists in diagnosing tumors is explained by the position of the different sections.

The round celled infiltration of ulceration can easily be mistaken for small round cell sarcoma, and with excuse. Sections from many parts of any growth should be studied before a safe opinion can be ven-

tured as to malignancy or non-malignancy.

DR. DEFOREST WILLARD: Much as I respect the valuable services of the pathologist, I am still inclined to rely more upon the results of clinical experience.

DR. BENJAMIN LEE: The case impresses me very clearly as one of malignant disease. The peculiarities of the tumor, the nodes alternating with small areas of fluctuation; the size of the fungus excrescence seem to me very characteristic, and not what we should find in a tubercular abscess. I noticed no sinus at the point of incision and excrescence. The sinuses are old ones in connection with the tubercular disease of the joint. The excrescence came from a new growth, with a history of only a few weeks. I cannot conceive it possible to have this fungoid condition as a result of tubercular disease.

#### PHILADELPHIA COUNTY MEDICAL SOCIETY.

*Meeting February 14, 1894.*

Drs. Keen and Mitchell presented a paper entitled

#### REMOVAL OF THE GASSERIAN GANGLION AS THE LAST OF FOURTEEN OPERATIONS IN THIRTEEN YEARS FOR TIC DOULOUREAUX.

##### DISCUSSION

DR. JAMES HENDRIE LLOYD: I had the opportunity of witnessing this operation by Dr. Keen, which has been followed by such brilliant results. I wish simply to discuss briefly the pathological aspect of this case, and to refer to a case which I have had under observation within the last year, and in which the termination has been satisfactory although no operative treatment was employed. With reference to pathology, it has been customary to attribute this affection to a peripheral origin and to fight it back, step by step, until, as it were, we reach it in its central location. I think that that should teach us that probably the disease is not really of peripheral origin in all cases, but that in some of these cases it is essentially a disease of the ganglion itself, and that probably the reason that so many of these operations fail is because at first the operation is confined to one or two isolated nerve trunks. The sensory nervous system originates in the ganglion. It is not of medullary origin in any sense. Embryologists and histologists know that the central nervous system is divided into two zones or areas, the so-called zones of His. The medullary zone including the motor system springs entirely from the cells of the anterior horns, and the sensory zone springs

entirely from the ganglia of the posterior nerve roots. These ganglia of the posterior nerve roots, especially in the embryo, are of great relative size and importance and of considerable complexity of structure. As late as yesterday I had the opportunity of studying sections of the cord of the embryo pig. In these I was struck with the great size and evident importance of the ganglia of the posterior nerve roots from which the whole sensory system springs. They are almost one-quarter as large as the cord itself. The importance which I attach to this, especially in cases of this kind, is that we can readily see the analogy that may exist in diseases of this sensory zone and diseases that exist in the motor zone. It is well known clinically that some of our more important, progressive, and chronic diseases of the motor system originate in the multipolar cells of the anterior cornua. These diseases, such, for instance, as progressive muscular atrophy, are slow and insidious and attack the nerve cells one by one, and with this there is corresponding deterioration of the nerve fibre and ultimately of the muscular fibre. We can readily see that in diseases like trifacial neuralgia we may have an analogous condition in the centres which are in the large ganglia of which the Gasserian is a type. I think that in some of these cases we have a slow, insidious process going on in these ganglia which is reflected outward through the affected nerve trunks. These nerve trunks are attacked by the surgeon, but the insidious process keeps on and is reflected out over more and more of the nerve trunks that are left. This

is pre-eminently the history of these operations on the fifth nerve. This fact suggests to my mind that in all probability this trouble, just as is progressive muscular atrophy, is a disease of the ganglionic nerve cells.

The fact that a neuritis is found by the microscope in the excised nerve trunk does not in any sense invalidate this theory. The neuritis may easily be a continuation outward of a central process.

If this view is correct surgeons are amply justified, since Rose, Keen, and others have shown the way, in attacking this obstinate affection in its head centre, which in this case is the Gasserian ganglion. There is nothing irrational, although there may be something theoretical in this view. I hope that in this particular case there will be a thorough microscopical study made of the condition of the Gasserian ganglion.

There are a few of these cases, which undoubtedly do well without surgical interference. It may be that the recovery is only temporary and that in time to come such cases will have a recurrence. I have had under observation for several years a lady who has had excruciating neuralgia of the inferior dental nerve at the point where it emerges from the mental foramen. The last attack continued for nine months. The pain was almost strictly isolated to the distribution of the nerve on the chin. In addition, however, there were occasional shooting pains through the lingual or gustatory nerve. This is an important point in connection with the pathology. It indicates that the affection was not peripheral. The lingual and inferior dental nerves are branches of the inferior maxillary branch of the fifth nerve. They emerge almost together from the Gasserian ganglion, but afterward have little mutual relation. The supposition, therefore, in such a case is that there was a central origin of the pain. In that case operation was considered, but not recommended. I was gratified to find that in this case expectant treatment, although long continued and including a trip to Florida, brought the suffering to a point where it could be borne with patience. Whether or not it will return and attack other nerve trunks remain to be seen.

DR. WHARTON SINKLER: When we come to consider the pathology trigeminal neuralgia, there is a great deal that might be said.

I am not prepared to accept fully Dr. Lloyd's view that the origin of the disease is to be found in the ganglion, for one sees many cases in which the neuralgia is to be traced directly to some peripheral irritation. It also seems scarcely probable that if the disease were always central excision of the nerve would be followed by relief lasting for several years, as is often the case.

The tendency toward surgical interference in neuralgia of the fifth nerve has increased very much of late years, Dr. J. J. Putnam expressed the opinion in a recent paper, that it is not worth while to attempt medicinal measures in these cases, but urges the excision of the nerve as far back as possible be at once resorted to. Dr. Keen goes further and makes the suggestion that it may be desirable to begin at once with the removal of the ganglion. It seems to me that these measures are too radical. We know that in excision the ultimate results are far from satisfactory, and like the relief from nerve-stretching, it is of brief duration. In the case of the operation for removal of the Gasserian ganglion, we do not know how permanent the relief may be. In all of the five cases operated on by Rose there was relief up to the time that the cases were reported, but the longest time after operation in any case was only twenty-two months, and in one of the cases the operation had been done only sixteen days. Then we must consider the mortality which follows the operation. According to the statistics given by Dr. Keen, forty cases have been operated on with six deaths, a death rate of fifteen per cent., which is a rather formidable mortality in a disease which does not threaten life. It therefore seems to me that before resorting to operative procedures we should use other remedies. There are certainly many cases that are relieved by medicinal means—that is, by the administration of drugs and the use of galvanism. I have now under my care an old lady over eighty years of age, who for the past five or six years has suffered from the most violent attacks of tic douloureux, and who is most invariably relieved by gelsemium pushed to physiological doses. Of course, when drugs fail, we must be thankful for having the opportunity to resort to an operation which has given such complete relief as excision of the Gasserian ganglion. I notice by the way, that Horsely questions very much whether the entire ganglion has ever been removed. He doubts if this be possible.

DR. FRANCIS X. DERCUM. I have little to add to what has already been said. I think that in these cases we should be guided rather by what we know of the pathology. While Dr. Lloyd's speculations are interesting, I hardly think that we can allow them to guide us in the choice of so radical an operation which is not without some danger.

It is certain that in some of these cases, at least, there is inflammation present in the nerve trunk itself. I know of at least four cases in which the microscope shows actual lesion in the nerve trunk to account for the pain. In one case where the infra-orbital and the inferior maxillary nerves were re-

moved, complete relief was afforded until the death of the patient some years later.

With regard to medicinal measures, I think that a definite plan should be pursued. We should in these cases search for diathetic troubles. In some cases we find the rheumatic diathesis, and even if it is not present, a short course of the salicylates will do no harm. I have seen the salicylates in full doses give great relief, so great that the patient would be without pain for months. It has occurred to me that we might also make use of piperazin, which in chronic form of nerve trouble is often of extreme value. In fact, some of the principles that guide us in the use of drugs in the treatment of sciatica should guide us in the treatment of this trouble, which is far oftener a neuritis than we are apt to think.

With regard to the possibility of excising the entire ganglion. It seems to me that it is possible to destroy the great bulk of the ganglion—at least, the posterior two-thirds. Whether or not the part supplying the ophthalmic region was touched in this case, I cannot say,

DR. JOHN B. ROBERTS; I am interested in the fact that the mass of gauze did not produce any great amount of disturbance. This only enforces what I have had long on my mind, that what we usually call compression of the brain is probably nearly always inflammation. We can have a good deal inside of the skull, such as bone or clot, with a very few symptoms, if sepsis be excluded. I do not believe much in compression of the brain after fracture, but think that the symptoms are nearly always due to inflammation the result of the irritation and probably a septic irritation of the brain tissues. That may not be neurologically correct, but it has stood me in good stead surgically as a clinical experience.

The elaborate engine shown, seems to work very satisfactorily. For my work, however, I would rather use a sharp chisel and a mallet with my hands, than any mechanical device.

These are apt to get out of order and must be kept in a place such as a hospital where they can be readily put in repair. What we want to do is to train our hands to do the work and not be dependent upon any mechanical device. The patient whom I shall show was operated on for intra-cranial neurectomy with great satisfaction with a small chisel, not the ordinary chisel for operating on the large bones, but such as we would use for delicate work, and one having the shape of a small osteotome. The chisel should be very sharp and the corner of it should be used for cutting the groove in the bone. I am getting into the habit of using the chisel rather than the trephine and am coming to think that the trephine is a little oldfashioned.

This is the man whose case I reported a year ago, and showed the second and third divisions of the fifth nerve, which I had excised in front of the Gasserian ganglion for tic douloureux. The man had had neuralgia for many years and had been operated on peripherally many times with relief for six or ten months, or even a year or two. I ligated the carotid artery, giving relief for a year; but the pain returned, and a year ago last December I did the intra-cranial operation, making the osteoplastic resection of Hartley, removed the second and third divisions of the nerve back to the Gasserian ganglion, but did not get out the ganglion. He has been absolutely comfortable for the last fourteen months. This man had no inflammation of the eye following the operation. I stitched the lids together before opening the skull. The nerves removed have been submitted to a pathologist, but so far I have had no report.

Here is another man on whom I have done a different operation for the same affection. He had intense neuralgia of the infra-orbital. I excised the nerve and he had comfort for two years. Two and a half months ago he came back saying that the pain had returned. Not thinking it proper to at once go into the interior of the cranium, I resected the ganglion of Meckel. I made an inverted V-shaped incision over the zygoma, familiar to all surgeons, sawed the zygoma in two places, turned down the musculo-osseous flap, and sought for the ganglion in the pterygo-maxillary fossa. I did not recognize the ganglion, but tore out what was in its vicinity. The internal maxillary artery was divided in the operation. The patient has comfort now, but it is only two months since the operation.

In another case ligation of the carotid afforded relief for a number of months, but then the pain returned. It seems to me, therefore, that the proper method is to begin peripherally excising the painful nerves and to repeat the operation as the pain returns until we finally get back to the ganglion of Gasser.

DR. BRUCE BURNS: I certainly believe that Dr. Lloyd is right, that in a certain number of these cases the affection is due to changes in the ganglion. In selecting the treatment of these cases a great deal of differentiation is required. There may be some cases arising from the periphery as the result of neuritis, neuroma, exotosis, etc. I have had some experience in operating on these cases. While the immediate results have been satisfactory, the results as regards ultimate recovery have not been good. One case was that of a lady sixty-five years of age, who had suffered from severe neuralgia for over thirty years, most of the time being con-



finied to bed. She had become an opium-eater and relied on large doses of whiskey or brandy for temporary relief. The teeth had long ago been extracted. After watching the case and knowing that medical measures had been given a thorough trial, I advised operation. In that case I trephined the superior maxillary and removed an inch and a half of the infra-orbital nerve; I also resected the inferior dental nerve in its whole length. Relief followed and continued for about two years. The pain returned and the general condition was so bad that I hardly thought it advisable to recommend further operation. The patient insisted that something be done, and I finally determined to attempt the removal of the superior maxillary bone. Before the operation was concluded the shock became so extreme that I desisted and the patient died shortly afterward.

Within the last twelve months I have had another case which I think is of ganglionic origin. There I removed the infra-orbital and the inferior dental. This gave a great deal of relief until a few weeks ago, when after exposure to cold there was a return of the trouble.

As I said before, I believe that in our treatment we should differentiate between the cases that are of peripheral and those that are of ganglionic origin.

DR. EDWARD JACKSON: In describing the operation, reference was made to the obstacle of bleeding at two separate stages; one due to rupture of a branch of the anterior meningeal artery was promptly controlled, and the other occurred on raising the brain, was not clearly accounted for, and caused the suspension of the operation. In conversation, Dr. E. W. Stevens has mentioned to me a point in anatomy that throws light upon this. In the dissecting-room his attention has this winter been directed toward this operation, and he has almost constantly found two veins of considerable size entering the bone at this point, so that they would necessarily be torn in the separation of the brain from the floor of the skull in order to get sufficient room to reach the ganglion.

THE PRESIDENT, DR. WILLARD: Having had occasion in the last few months to look up this subject, and as the operation of Rose has not been described to night, it may be of interest to show diagrams illustrating Rose's operation. This operator cuts through the zygoma, saws off and turns back the coronoid process, and ligates the internal maxillary artery. He then reaches the foramen ovale and applies a trephine directly beside the nerve and then through this opening removes the ganglion with a curved hook. This route will probably be selected by surgeons unaccustomed to intra-cranial work.

Rose reports 7 cases with only 1 death from meningitis, and Andrews 4 with 1 death. In a collection of 40 cases which I have made, there were 6 deaths. These cases represent results obtained both by the Rose and by the Hartley or Krause method.

With regard to the removal of the entire ganglion, it has been almost the universal experience of operators, either through the speno-maxillary fossa or within the cranium, that while they have believed that they have excised the ganglion, they have not been at all certain that the entire mass was removed.

DR. KEEN: I regret that I was prevented from arriving till so late that I am not able to take part in the discussion. I wish, however, to show the electric lamp to which reference has been made. The lamp is that made by Hirschman, of Berlin. The storage battery is made by Mr. Fleming, of this city. The battery has ten cells and is provided with two rheostats, so that with one I can use the electric light or galvanic current. The other can be used for galvanocaustic purposes. In the lid is a large compartment in which the lamp, etc., may be carried.

DR. MITCHELL: As to the origin of this affection, it seems probable that in many of these cases the origin is not central. This point was discussed in the paper. While such an origin is possible, I do not believe that it is always or commonly the case. If the disease originated in the ganglion, operations on the peripheral nerves would not give the relief that we find to follow in many of these cases.

#### Ruined his Prospects.

Dismal Dawson. "They's is one feller, if I ever meet him, I mean to beat the face off him."

Hungry Higgins, "Who is he?"

Dismal Dawson. "The doctor that doctored in our family when I was a kid. Ef it hadn't of been for his fool interferin' I might be takin' in plenty of money every day on them fits right now."—*Indianapolis Journal*.

ALLOPATHIC CURE. — If your piano does not work well, open the top and pour in a pail of strong soap suds and brine. HOMŒOPATHIC CURE.—If your piano does not work well drop a grain of sugar in one of the hollow mahogany legs.—*Minneapolis Journal*.

All people have their trials, except perhaps, the rich rascals who can suppress the indictments against them.



## THE LIBRARY TABLE.

## BOOK REVIEWS.

*Antiseptic Therapeutics*, E. Trouessart, translated by E. P. Hard, 2 vols., constituting part of the Physicians' Leisure Hour Library, published by Geo. S. Davis, Detroit; 25 cents for single numbers; \$2.50 per annum.

The first volume discusses the antiseptic and toxic powers of inorganic and organic chemicals; the second volume is classified by diseases, ending with an abridgement of the author's third part on antiseptics in hygiene and nursing. Antiseptics are made to include not only substances ordinarily so considered, but remedies which neutralize toxins, whether produced by a bacterium, a fungus, or even by perverted cells of the body, as in rheumatism and gout. Some excellent generalizations are made as to the relation between antiseptic power and chemical constitution. We are told that "The group naphthyl,  $C_{10}H_7$ , is about twice as antiseptic as the group phenyl,  $C_6H_5$ , and the latter is five or six times more energetic than the group methyl,  $CH_3$ ."

We are pleased to note that the metric system is used, with few exceptions. A number of inaccuracies detract from the value of the work for ready reference, although they are mainly self-correcting if the books are carefully read. The work is a little disappointing, not from any fault of the author or translator, but on account of the present lack of precise information. Its special value is to present facts already known in a new light and to stimulate further experimentation with internal antiseptics.

*How to Use the Forceps*, with an introductory account of the Female Pelvis and of the Mechanism of Delivery, by Henry G. Landis, A.M., M.D., Professor of Obstetrics and Diseases of Women and Children in Starling Medical College, Columbus, O. Revised and enlarged by Charles H. Bushong, M.D., Assistant Gynecologist and Pathologist to Demilt Dispensary, New York. Illustrated. New York: E. B. Treat, publisher, 5 Cooper Union. 1894. pp. 203. Price, \$1.75.

This book contains a very clear and concise account of the pelvic canal, from the standpoint of the obstetrician, as well as the method in which the fetal head passes through it. The criticism to be made is rather on what has been left out than what has been said.

For instance, concerning the question, Why does internal rotation occur especially in posterior positions?, the author makes no mention of the pelvic soft parts, but assigns the cause to inclined planes of the bony canal, torsion of the neck, etc. Now it is generally admitted that the chief factor in internal rotation is the resistance of the soft parts to the most advanced part of the fetal head, and the most important component of the soft parts is the levator ani muscle. Much importance is given to the perineal body as a force in labor, and the author states that "the muscles attached to the fibrous perineal body should be considered as a part of it when de-

scribing it." However, the following sentence will disclose the lack of his appreciation of the function of the levator ani muscle: "As the head escapes from the vulvar orifice the perineal tissues retract to nearly their original condition, chiefly by reason of their inherent elasticity, aided somewhat by the action of the transverse muscles of the perineum."

Concerning the kind of forceps to be used the author expresses his preference for the Davis forceps. He finds this, *properly used*, all sufficient for traction in the axis of the birth canal. He alludes to the Tarnier forceps as "an unnecessarily ingenious contrivance." The fact that the latter admit of natural internal rotation and flexion and extension while traction is being made, does not seem to have outweighed the other in usefulness in his estimation. As to anesthetics when using the forceps, the author says, "the use of anesthetics is neither necessary nor advisable."

The book is a very instructive one, and will amply repay careful study on the part of any one who is interested in this branch of medicine.

*Lehrbuch der Fracturen und Luxationen, fuer Aezzte und Studierende*. Bearbeitet von Dr. Albert Hoffa, Privat-docent der Chirurgie an der Universitaet Wuerzburg. Second augmented and improved edition, with 395 illustrations in the text and 29 colored plates. 705 pp. Stahl'sche Hof-und Universitaets-Buchhand Kunst-Handlung. Wuerzburg.

This eminently practical work on fractures and luxations is written by one who is well known in surgery, and especially in orthopaedic work. It is intended to present a clear and practical exposition of the subject to both student and practitioner, and to present this subject in the present condition of surgery. Therefore has attention not only been paid to pathological anatomy, but also to differential diagnosis and therapeutics of the various conditions, so that with simple means one may obtain good results. Of the various means of bandaging and dressing only those have been included which have stood the test of time and experience. In order that one may have a clear idea of the subject there are incorporated, in the text, numerous illustrations, with a series of colored plates, at the end. In the explanations he has sought to present all the relations which might assist dislocation of the fragments and to bring forward types which, once seen, the deviations may be easily noticed. The consideration of each subject is full and quite complete, and well up with the advances in this branch of medicine. The second edition has undergone many improvements and much elaboration. Above all, the writer has sought to include recent advances with regard to both the German and foreign literature. The new methods of treatment have been tried on the material under his care, as much as possible, and that incorporated which has been found practical. The rarer fractures and luxations are rendered

clearer and more easily comprehended by including histories of cases and pathologico-anatomically well analyzed cases, in the text, together with a number of new figures. It has met with a favorable reception in Germany.

*The Year-Book of Treatment for 1894.* A comprehensive and Critical Review for Practitioners of Medicine and Surgery. In a series of twenty-four chapters, by eminent specialists. In one 12mo. volume of 497 pages. Cloth, \$1.50. Philadelphia, Lea Brothers & Co., 1894.

In the ten years of its publication, *The Year-Book of Treatment* has firmly established itself as an invaluable aid for all those who desire to keep posted on the current additions to the world's knowledge of the management of disease. The word "treatment" is construed in its broadest sense, including

medicine, surgery, gynecology, obstetrics, pædiatrics, and all the specialties, in a series of twenty-four chapters, each contributed by a gentleman eminent in his assigned subject. Bacteriology and hygiene are compendiously dealt with, and the Summary of Therapeutics for the year presents this most important subject in the most available form for use. The various articles are sufficiently detailed for all practical purposes, but references to original papers are given for the convenience of those desiring to make extended research.

The volume contains a "Selected List of New Books, New Editions and Translations," which will give the reader a knowledge of the latest and best literature under each head. The Index of Authors Quoted, and Index of Subjects, complete and close a volume which is authoritative, well arranged, serviceable for every medical man, and universally available, owing to its very moderate price.

## CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

### ARCHIVES OF PEDIATRICS.

In the March number, Dr. A. Brothers contributes an article on the

#### *Treatment of Empyema in Early Life.*

giving an historical review of the methods that have been resorted to.

Operations he classifies under the heads of puncture and methods by the knife.

This article covers the subject very completely, giving as concisely as possible the differences in the operations practiced by different men, and finally the author concludes with his own experience, and his reasons for preferring incision to puncture with the aspirator.

Puncture with the aspirator the author thinks useful to temporarily relieve a case, until the system can be built up and incision made.

In children, section of ribs is rarely called for, unless the case is one of long standing. In adults, however, the case is different, and it is usually necessary to divide one or more ribs to insure the closure of the cavity. As soon as pus is diagnosed, the author declares the only treatment to be prompt and free incision with drainage.

Dr. George Carpenter writes of the

#### *Incubation Period of Scarlatina, etc.*

Most authors, he states, declare the incubation to be from two to eight days, but the writer quotes cases which seem to show that it may range from two days to three weeks. This should lead to a longer period of quarantine of those convalescing from this disease than is at present demanded by law. The author emphasizes the fact that so long as desquamation is taking place, whether in the scalp or elsewhere, the patient is capable of acting as an infecting centre to others.

whiskey, in diphtheria. The drug has sev-

Dr. Talbot R. Chambers gives his experience with tincture of nux, as a substitute for ernal advantages and was used in dose sufficient to sustain the pulse, etc., in about its normal condition.

In the first case mentioned the required dose was one minim every half hour at first, and less frequently later on.

Dr. D. J. Milton Miller writes of the value of alkalies and aromatics in digestive disorders of children.

In the condition known as mucous disease, due to improper feeding, the author states that combination of these two classes of drugs acts by the solvent and antacid power of the alkalies, and the power aromatics have of dissipating pain and spasm. Alkalies also, when diluted and given on an empty stomach, appear to stimulate the secretion of gastric juice. The author describes some typical cases and his treatment of them. Besides restricting the amount of farinaceous food, he administered soda bicarb., sp. ammonii aromat., glycerin and aqua mentha, with or without sp. chloroform, and tr. capsicum.

### JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

Dr. John T. Bowen, reports a case of

#### *Hydroa Vacciniformis*

the first, he believes reported in America. The patient was a white boy, and without important family history. Since five years of age, the boy has had after exposures to the sun, repeated attacks of this trouble, more frequent in Summer. He has never been free for more than two months at a time, even in the winter season.

Of late a few lesion appeared on the hands, also, but usually the face alone was affected. Sometimes an attack was ushered in with malaise and vomiting; sometimes not.

The patient is undersized and anæmic, with face, especially the nose and malar prominences, covered with cicatrices precisely resembling those of variola: these cease gradually at the hairline of the scalp.

The eruption consists first of red papules, which become vesicular and vesico-pustular. These may now enlarge, and sometimes present a marked umbilication surrounded by a clear or turbid fluid, which in turn is circled by an erythematous halo.

Only the most advanced lesions are umbilicated, and the centre of these presents a peculiar dark blue or black aspect, which is due not to the contents but to the floor of the lesion, and in many cases, the author states, this dark floor presents points of still darker color. The lesions may become confluent.

During the next stage the dark centre and its covering are replaced by a very adherent thick black crust, which is finally cast off, leaving a deep punched-out pit, usually circular, and at first deep red in color.

The author states there was no pigmentation, but in some places new lesions were forming in old pits. Few sores appeared on the hands, none above the wrists, and none on any other parts of the body.

The cervical, submaxillary, and inguinal glands were enlarged but all others appeared normal.

Under the use of a carbolized zinc oxide lotion, and the internal use of iron, the case improved more rapidly than usual, but had a second attack after a short respite. Another and more severe attack came on after going out on a sunny, but very cold December day, and this time the face was much swollen at first. Itching rarely occurs in these cases, although it was a prominent symptom in this one, and the attacks grow milder as the patient grows older, until they disappear in adults.

Microscopic examination of a typical lesion shows necrosis of both epidermis and corium, reaching almost to the subcutaneous tissue, but ceasing very abruptly at both the side and bottom. Near the lesion the epidermis is thickened and the corium full of small round cells. Hair follicles and sweat glands are numerous and normal. Examination for micro-organisms gave no results of importance. Examination of a less fully developed papule showed that the trouble begins in the epidermis and upper part of the corium, and if at this point improvement does not set in the part involved and the corium immediately underneath become necrotic.

The necrotic process differs from that of variola in being secondary to the vesiculation, while in variola Weigert found necrosis to be primary.

As in all other skin diseases where umbilication appears, it seems due to the central necrotic area holding down the centre of the lesion, while the epidermis around is allowed to proliferate and form a raised border.

The treatment has not been very successful, the author says, but veils of red or turmeric colors, by neutralizing the chemical rays of the sun, would go far toward preventing the disorder.

Dr. Heumann G. Klotz writes on

#### Antisepsis in the Treatment of Eczema.

This principle, he says, now so carefully observed in general surgery, is neglected greatly in dermatology, where the conditions are generally such as to invite sepsis constantly.

The reason for this neglect, the author thinks, is due to the fact that the drug in most general use to prevent sepsis elsewhere, carbolic acid, is injurious to the skin and often seems, unless used with extreme care, to render any irritation of the skin worse. The author prefers to use weak solutions of bichloride of mercury, 1:3000 to 1:5000, preferring solutions in almost all cases to ointments, contrary to the usual teaching of dermatologists. He also has success with boric acid, sometimes uses it in ten per cent. ointment after applying a bichloride lotion for a time. The author goes on to show that almost every one of the so-called soothing lotions in popular use for a long time are of more or less antiseptic value, (even infusion of chamomile) and the ideal preparation is one which, while not strong enough to be irritating, is yet antiseptic and which will favor new skin production. The author then mentions ichthylol in 1 to 1,000 or 2 to 1,000 strength, salicylic acid, thymol, resorcin, etc., but seems to prefer a mixture of fifteen or twenty grammes of boric acid, two to five grammes acetate of lead, a half pint of lime water with enough boiled water to make a quart; sometimes adding to this a small amount of glycerine and alcohol.

Dusting powders are useful and are preferably made of boric acid, etc., with some mineral powder such as talcum, magnesia carbonate, or kaolin, rather than vegetable preparations, such as starch. Some of the plasters in common use, the author thinks ideal antiseptics, requiring only the addition of cotton or some absorbent to make them perfect.

Dr. J. H. Pooley describes a case of

#### Molluscum Fibrosum.

the subject being a man, now fifty-eight years old, who when a boy of ten years had an attack of so-called erysipelas. During convalescence the skin peeled off from face and body, and shortly afterward a number of small elevations appeared over the body. These are scattered over the head, neck and limbs, the author says, but over the back and chest are as thickly placed as possible. Microscopically they prove to be molluscum fibrosum and the only noteworthy features are their uniform size, and their apparent connection with the erysipelas. No known family history throws any light on the case.

#### THE EDINBURGH MEDICAL JOURNAL

for March contains a paper by W. G. Aitchison Robertson, M. D., on



### The Fermentation of Sugars.

As the result of the author's investigations he presents the following practical deductions:

In cases of dyspepsia there is usually much delay in the absorption of carbohydrates, even when digested. They are consequently exceedingly prone to undergo fermentation, and this is specially apt to occur if the carbohydrate be in slight excess.

In that variety of dyspepsia accompanied by lactic fermentation, the use of those sugars which rapidly undergo the lactic change, viz., dextrose, lævulose, and invert sugar, is contra-indicated, while the moderate use of cane sugar, maltose, and lactose may be allowed.

In those cases of dyspepsia where butyric fermentation is prominent, milk sugar would seem to be the most suitable, as it is least easily changed by ferment. On the other hand, maltose is very readily changed, as the other sugars also are to a lesser degree.

Lastly, in dyspepsia associated with the alcoholic and acetic acid fermentations, cane sugar, dextrose, maltose, and lactose may be allowed in small amounts; while invert sugar and lævulose should be forbidden. Lactose, however, is the sugar to give in this condition, as it is not at all acted on by the alcoholic ferment.

These theoretical deductions have been supported by clinical observation in the case of cane and invert sugar. The author leaves it for future investigation to show whether they are true as regards the other sugars.

F. W. N. Haultain, M. D., contributes a paper on

### Dilatation of the Cervix by Champetier De Ribes's Bag.

The instrument simply consists in a silk bag covered by india-rubber, which, when distended, assumes the definite shape of an inverted cone, measuring at its base about  $3\frac{1}{2}$  inches in diameter.

For the purpose of introducing the dilator, a pair of separable forceps have been devised, which are of great value when the initial dilatation is not greater than the diameter of a quarter dollar; but when larger than this, the introduction of the bag can be most conveniently performed by means of a pair of ordinary curved vaginal forceps.

The not inconsiderable dimensions of the collapsed bag make it necessary that a certain amount of initial dilatation requires to be present before introduction can be attempted, the amount necessary being slightly larger than the diameter of a quarter dollar; or, in other words, the os requires to admit one finger fairly easily.

Before introduction the bag should be crumpled into as small a compass as possible and thoroughly oiled. It is then grasped by the application forceps and slowly pushed through the cervix till at least a half has passed the os internum.

The forceps are now loosened, and partial distention (by means of warm water pumped in by an ordinary Higginson syringe) commenced; the forceps are now withdrawn and

full distention completed, this being estimated by a known number of syringefuls being necessary.

As the bag distends it becomes accommodated to the surrounding parts and adapted to the existing degree of cervical dilatation existing, its curved shape allowing it easily to lie on the axis of the pelvic brim.

From the large size of the bag, the pressure on the presenting part must necessarily be considerable, and thus tend to displacement, — a disadvantage in its use.

The bag in its shape corresponds with the normal bag of waters for which it forms a most excellent substitute, as the author has on more than one occasion proved. But as a simple substitute for the normal membranes its benefits as a dilator are by no means exhausted, because when rapid and more forcible dilatation is required it is of great service in forming a most efficient point of resistance to the finger in performing digital dilatation. Further, by making traction on the bag considerable assistance can be given to feeble uterine contractions, and even dilatation attained where they are entirely absent.

Although the main function of the instrument is as a dilator, it must undoubtedly act beneficially in cases where the membranes have been long ruptured, by preventing compression of the soft parts between the presenting head and the pelvis, through forming a basis upon which the foetal head rests. This action upon the presenting part where exaggerated, although forming one of the stated objections to the use of the bag, must be looked upon in some cases as of distinct value, as where compression of the cord is thus avoided.

The author believes that the instrument is of especial advantage in the induction of premature labor in which operation it has been extensively used in France.

As regards any special danger in using the dilator, the only one which suggests itself to his mind is the introduction of the bag in cases where after prolonged labor the lower uterine segment has become much thinned; here its introduction may be the means of causing rupture of the uterus, otherwise its employment under ordinary antiseptic precautions seems at all times safe.

Appended to the paper is the report of several cases in which the author made use of the bag.

W. Ramsay Smith M. B. describes a

### Definite Form of Skin Disease Allied to Erythema and Urticaria.

The first time he saw the rash was on an infant six months old. The eruption, which partook of the nature of an erythema or an urticaria, was distributed pretty much all over the body, but was specially abundant in a zone round the upper part of the abdomen.

The spots were single, as a rule, although here and there some were so close as to appear confluent. The appearance of the spots raised a strong suspicion that they might be due to the bites of insects. The boy had been in the garden playing among grass, and several of the spots had a central mark closely resembling the injury inflicted by a sting or a



sharp pair of jaws. Subsequent observation convinced him that this theory was untenable. Some of the spots had no such mark, but were really wheals. The majority, however, consisted of white or very pale pink spots, varying in diameter from an eighth to half an inch, becoming red within an hour or two, and then fading away in four or five days,—other crops appearing in the meantime, and running a similar course. Some of the "spots" became hard and shotty in the skin; some, especially on the dorsal aspect of the fingers and toes, became almost warty, and remained for a week or more; and others became vesicular, and burst, exuding a clear coagulable fluid. The skin, in these cases, would take two or three weeks to assume its normal appearance. Intense itchiness of the skin, and a considerable amount of constitutional disturbance, were associated with the appearance of the rash. The attack passed off, but recurred after a few weeks, when the same train of symptoms was repeated.

The author describes five other cases of the same disease. He relies chiefly upon constitutional treatment. In children most benefit seems to arise from a smart purge of calomel. He has tried quinine in large doses at the beginning of an attack, and also antipyrine, both with some degree of temporary advantage, but he puts the most trust in the efficacy of calomel. In adults the disease is often very troublesome, and sometimes the treatment is very prolonged and the improvement very slow indeed.

This issue of the journal also contains the second of the Morrison Lectures on Insanity by John Batty Tuke, M. D. John Wylie, M. D., continues a paper on "The Disorders of Speech;" this number being devoted to the consideration of aphasia and other disturbances of speech in relation to evanescent organic affections and functional disorders of the cerebral cortex. James Ritchie, M. D., discusses "Prolapse of the Bladder during Pregnancy and Parturition," reporting a case.

## PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

### THERAPEUTICS.

#### Atropine in Morphinism.

Prof. W. Kochs, of Bonn (*Therap. Monthsh.*). Last year the author had occasion to treat a case of severe morphinism, in which considerable quantities of the drug had been taken, and very alarming symptoms were produced. It was necessary to directly counteract the poison; five times during ten months Prof. Kochs used, in this case, atropine with the very best results. The patient was dismissed, but returned repeatedly, falling a victim to the habit. The author states that, to his knowledge, atropine had not, until then been used in morphinism, and considers that the symptomatic antagonism of these two drugs has not been sufficiently appreciated. Many do not accept the view that atropine is capable of contracting the action of morphine.

It is well to begin with very small doses of atropine subcutaneously (0.0002 gme. [1-333 gr.]) and double the dose if necessary.

#### Some Points in the Treatment of the Uric-Acid Diathesis.

F. E. Stewart, M. D., Ph. D. (*Therap. Gaz.*).

The author's main idea in the above paper is to prove the great efficacy of warm saline baths, as given at certain springs in Germany and in the United States, in the treatment of the uric-acid diathesis. He recommends that in conjunction with the baths there should be administered potassium bicarbonate, in doses of forty grains, to render the urine alkaline; and that a diet be maintained of animal food: milk, 1 to 1½ pints, eggs, fish, fowl, or game, 1 to 4 ounces varied a little

from day to day. Of vegetable food, vegetable prepared products, vegetables twice a day; fruit three times a day, to any desired extent, according to appetite. Tea, coffee, cocoa in moderation, and as flavorings rather than as strong decoctions. He also recommends exercise in the open air, preferably under conditions where the mind as well as the body will receive excitation; and indoors by light gymnastic practice, fencing, Swedish movements, and massage. He claims that in many cases the uric-acid diathesis can be successfully treated by the use of the natural saline baths (93°F.) by diet and exercise, without the administration of drugs; and in cases where drugs are necessary, their salutary effects are increased by the baths, etc.

#### Absorbing Power of the Bladder.

Physiology has hitherto taught that the bladder is one of the organs which are covered with epithelium and which possess no absorbing power. The author states that clinical observation led him to suppose that the healthy bladder must certainly possess some absorptive power. His experiments consisted in the injection of certain chemical and microbic poisons within the bladder by means of a catheter. Only a slight amount must be injected, so as to avoid the effects of pressure and not cause the animal to urinate at once. Cocaine, strychnine, and medicinal hydrocyanic acid killed the animals within a few minutes. Water appears to be absorbed to some extent by the bladder, but no absolute proof of this can yet be given. The absorption of chemical poisons by the bladder may throw some light upon urinary pathology and give an explanation of the fact that,

from the evolutionary standpoint, renal retentions allows of longer preservation of life and health than retention within the bladder.

Pneumococci, septic vibrios, and the pyretogenic substance of Charrin, when injected in the bladder, all caused death in the majority of instances, after variable lapses of time. Death occurred in five out of six rabbits after pneumococcus injections, and pleural and peritoneal exudations were found to have taken place while there were no renal lesions.

## MEDICINE

### Eliot (G.) on Appendicitis from the Point of View of the Physician.

From an etiological, as well as from a pathological point of view, the patient with appendicitis has many chances of his disease terminating fatally. Before pus has formed, before ulceration has perforated the coats of the appendix, and before the appendix has become gangrenous and sloughed, the danger to the patient is a prospective one. During this stage of the malady, the physician must adopt a course of active medical treatment. Morphine should be administered in large doses subcutaneously, and should be repeated at short intervals until the pain is entirely relieved. A mustard plaster should be applied until the skin is reddened, and this should be followed by hot flaxseed poultices. A saline cathartic—sulphate of magnesia, in drachm doses, is the best—should be repeated every hour or two, until copious watery movements from the bowels occur. These measures tend to relieve the congestion of the intestinal mucous membrane, and to modify the inflammatory action. If the case is one of so-called catarrhal appendicitis, in which there is no foreign body and no abnormal concretion giving rise to the inflammatory process, the inflammation may undergo speedy resolution and the patient quickly becomes convalescent. But, on the other hand, resolution may not ensue, and the patient may not get well.

If, however, the trouble is caused by a foreign body, or an intestinal concretion, these measures will do little good, except to keep the patient quiet, while the doctor is thinking what to do next.

Cases of this kind, and cases of catarrhal appendicitis, which have not undergone resolution, may be classed together. They are of great gravity and importance. Unfortunately, during the first stage of the disease it is generally impossible to tell just what the cause of the trouble is.

How long may medical treatment be continued? For not more than twenty-four hours, and not later than forty-eight hours, from the commencement of the disease, unless distinct evidence of positive and continuous improvement is observed. If it is not observed, call upon a surgeon to operate, and call upon one who will operate. In this way alone will you do your duty by your patient.—*Boston Med. and Surg. Jour.*

### Rheumatic Skin Eruptions.

Dr. Travers Smith, of Dublin, quoting from Drs. Barlow and Cheadle, says that skin eruptions may be the only manifestation, present at one time, of rheumatism. The rashes, when widely diffused over the body, closely simulate those of measles, German measles, and scarlatina. The difficulty of differentiating is further enhanced by tonsillitis, which may owe its origin to a rheumatic factor. Attention to the following points generally enables one to form a correct diagnosis: (1.) The mode of distribution of the eruption, which manifests itself first on the extremities and may be entirely limited to them. (2.) The *tout ensemble* of the constitutional symptoms, *e. g.*, there being no distinct and sudden invasion or catarrh as in measles. (3.) The time of year. Most cases occur during the cold months and autumn. (4.) The possible concurrent prevalence of an epidemic of an exanthem should be ascertained. The evanescence of the rash and absence of subsequent pigmentation will exclude the syphilides. He quotes as follows from Dr. Cheadle's articles in Keating's *Cyclopædia*: "Always in the case of children, whether unmistakable arthritis be present, or there be merely a stiff and painful tendon, or an unexplained febrile attack, or chorea, or tonsillitis, or erythema, it is most essential to bear in mind the possibility of having to deal with rheumatism, and to examine the heart carefully day by day."—*The Dublin Journ. of Med. Science.*

### Olive Oil in Lead Colic.

M. de Prada records three observations, in which Weill and Combemale employed olive oil in doses of two hundred grammes as a deobstruent and sedative. These therapeutic effects have not been obtained by M. de Prada. The oil in this large dose is with difficulty assimilated by the patients, there being great gastric intolerance. He considers calomel to be superior to the oil; and that it is better to resort to salines, such as the salts of magnesium and sodium, or to calomel combined with sedatives, such as opium and phenazone.—*Lyon Medical.*

### Treatment of Infantile Eczema.

Harrison calls attention to the importance of regulation of the diet, and administration of alterations to the mother in the case of nursing infants. He has found small doses of arsenic (especially minute when the eczema is of highly inflammatory type) to have the best effect. In the way of local applications he prefers unguents to lotions and thinks there is nothing in the argument of non-cleanliness, for oils are really more deterrents than water.—*Amer Jour of Obst.*

### Antipyretic Pills in Phthisis.

**R** Pulveris digitalis ..... gr. j.  
Quininae hydrochloratis ..... gr. iss.  
Pulveris opii ..... gr. ss.  
Misce et fiat pilula.  
One to be given every six hours.

### Arsenic and Cancer.

Among the ingenious and plausible suggestions emanating from Mr. John Hutchinson, is the possibility of the evolution of epithelioma, being facilitated by a long course of arsenic. In his well-known paper on the subject he alleged a number of instances in which there was certainly presumptive evidence of arsenic having thus favored the evolution of the cancerous outbreak. At a recent meeting of the Clinical society, apropos of a case of multiple epithelioma following a course of arsenic, he called attention to certain peculiar changes in the skin of the palms and soles, which in his opinion indicate that it is time to desist from the administration of the drug, viz., a furfuraceous thickening of the skin in those situations. We call attention to this statement in order that our readers may avail themselves of any and every opportunity of ascertaining how far the suggestion is confirmed by clinical observation.—*Med. Press Notes.*

### Notes on the Physiological Action of Ozonizing Preparations.

Dr. W. G. Thompson draws the following conclusions respecting the effect of ozonizing agents when given by the stomach or injected directly into the intestines or the blood. The experiments were made on dogs.

1. When injected in the circulation in full strength, i. e., fifteen volumes per cent., they have a very destructive action upon the blood, ultimately having the effect of reducing rather than of oxydizing agents for the tissues.

2. Acting through the stomach or intestines, they may similarly affect the blood, and in addition they destroy the gastric and intestinal mucous membrane.

3. Given in medical doses by the stomach, their only benefit, if any, consists purely in their local action in the alimentary canal, in possibly preventing abnormal fermentations.

4. If so used, care should be exercised owing to the great variability in strength of different preparations.

5. Ozonizing is of no real value to the tissues, whether inhaled or drunk in fluid preparations, and it may be exceedingly harmful.—*Med. Rec.*

### A New Treatment for Tuberculosis of the Joint and Skin.

The old dictum that "all cyanosis was incompatible with tuberculosis," although originally applied to the lungs led to the suggestion that it might be equally useful in joint and skin affections of the same character. The technique of the method is simple. It consists in placing a broad elastic band around the affected limb a few inches above the diseased part, firm enough to produce venous congestion. The point of application should be changed from day to day to prevent abrasion. The distal portion of the limb is supported by a common roller up to the affected part so that the congested area is limited to the immediate neighborhood of

the disease. Dr. Bier of Kiel who originated the treatment reports upward of twenty cases in which the improvement attained was very rapid and striking. Miller reports in *Edinburgh Medical and Surgical Journal* cautiously this treatment. His plan differs from Biers, in that the bandage is only applied for ten or twelve hours on alternate days. He recommends its use in:

1. Tubercular skin affections of the extremities.

2. Early tubercular disease of joints, (combined with immobilization or blisters,) especially those in which time is of no great importance.

3. Instances of multiple tubercular disease in which more radical treatment is inappropriate.—*Med. Rec.*

### Dangers of Piercing the Ears.

Thorner calls attention to the pathological conditions following the piercing of the lobules of the ears, a custom he considers barbaric, not only because of its origin, and the crude methods by which it is practiced, but for its occasional consequences. Death has resulted from trismus, erysipelas and gangrene, while many observers have reported fibroid growths at the seat of injury, which tend to recur and may become malignant. Thorner reports from his own experience, cases of erysipelas, eczema of the auricle and tumors including fibroma and keloid. These cases lead him to believe that such consequences are more frequent than are usually thought, and he hopes that it will come to be considered an evidence of brutality to have a tender and unprotected child subjected to such an unnecessary and mutilating procedure.—*Jour. Med. Asso.*

### The Etiology of Eczema.

In a paper on this subject read before the Pan American Medical Congress at Washington, Sept. 1893, Dr. A. Ravogli draws the following conclusions:

1. Eczema is a local affection of the epidermis of a chronic inflammatory character, contagious under favorable circumstances.

2. It is caused by pyogenic micro-organisms (staphylococcus pyogenes albus) developed upon a previous inflammation of the skin.

### Treatment of Chorea.

Dr. Abercrombie makes the following suggestions in a clinical lecture concerning the treatment of chorea in children. Unless the attack is very mild, absolute rest of mind and body is essential. Lessons must be given up, and the child kept at home lying down. Most severe attacks demand complete rest in a bed with padded sides. In other severe cases the child should be slung as in a hammock. Only in the lightest attacks should the patient feed himself. When mastication is difficult, minced meat, strong beef-tea, milk, and cocoa should form the chief articles of diet. Sleep is of great importance. If



necessary, chloral hydrate, morphine, or bromides may be administered. Iron and arsenic are the best drugs, though drug treatment is of less importance than general management. Rheumatic manifestations or heart complications should be treated on general principles. In chronic cases douches to the spine, shampooing, massage, and gymnastics are of value.—*The Medical Record*.

#### A Bromoform Mixture for Whooping-Cough.

<b>R</b>	Bromoformi.....	mxvi.
	Spiritus rectificati.....	5j.
	Glycerini.....	5ssj.
	Tincturæ cardamomi compositæ.....	5j.
	Mix in the order given.	
	A teaspoonful to be taken every six hours.	

#### Signs of Commencing Pericardial Effusion.

In opposition to the almost universally accepted teaching that commencing pericarditis is first manifested by an increase (broadening) of the cardiac dullness at the base of the heart, Ebstein finds that the first alteration occurs in the lower regions of the area of dullness. At first there is a stretching of the pericardium towards the left side, but this is seldom discoverable, partly on account of the occurrence simultaneously of left pleurisy, partly on account of the overlying of the cardiac apex by the lung, partly on account of the loud tympanitic note in the semilunar space. After a short time the pericardial sac will be distended towards the right side also; and this enlargement may be recognized clinically in nearly every case by the appearance of an absolute, or almost absolute, dullness in the fifth right intercostal space in the region named by Ebstein the cardio-hepatic angle (*Herzleberwinkel*). The symptom is all the more demonstrable if it occurs under the observation of the physician, because the possibility of mistaking it for the other processes which bring about complete dullness in this region is entirely excluded. Further, this absolute dullness in the cardio-hepatic angle is of importance for the differential diagnosis between pure hypertrophy of the heart and accumulation of the fluid in the pericardium, because, according to Ebstein, so far as has been hitherto ascertained, absolute heart dullness between the fifth and sixth ribs, even in extreme hypertrophy of the right heart, does not extend beyond the right sternal margin. The cardio-hepatic angle marks also the spot at which, during the retrogression of pericardial effusions, the dullness remains longest observable. A series of clinical histories serves as a proof of the above propositions. — *Virchow's Archiv. Archivf. Klin. Med.*

#### For Laryngeal Phthisis with Dysphagia.

<b>R</b>	Cocaine hydrochloratis.....	gr. x.
	Acidi borici.....	gr. iv.
	Glycerini.....	mxv.
	Aquæ destillatæ ad.....	5j.
	Misc et fiat applicatio	
	To be applied to the throat when necessary.	

## SURGERY.

### Di-Iodoform in Simple Chancre.

Messrs. Hallopeau and Brodier have communicated to the Société de Thérapeutique of Paris their experience in twelve cases of simple chancre treated with di-iodoform. They arrived at the following conclusions. (1) Di-iodoform may be used in these cases in the same way as iodoform: it generally cures in eighteen to twenty days. (2) It is well borne, and produces neither pain nor local irritation. (3) It has the advantage over iodoform that it gives out no odour, provided it is kept away from the light in well-stoppered bottles. (4) It may, like iodoform, fail to cure in cases of phagedænic chancre. (5) It should be applied several times daily: the ulcer should be kept covered with absorbent cotton-wool impregnated with the drug. (6) It gave good results in a case of lymphangitic abscess of the penis, and generally it is applicable in the treatment of the suppurations and ulcers which are benefited by iodoform dressings. — *Le Progrès Médical*.

### An Application for Recent Ringworm.

<b>R</b>	Thymol.....	5ss.
	Chloroformi.....	5j.
	Olei olivæ ad.....	5j.
	Misc et fiat applicatio.	
	To be applied night and morning.	

## ARMY AND NAVY.

U. S. ARMY FROM MARCH 11, 1894, TO MARCH 17, 1894.

Leave of absence for six months to take effect on or about May 1, 1894, with permission to go beyond the sea is granted Captain Walter W. R. Fisher, assistant surgeon United States Army.

By direction of the president the retirement from active service, March 13, 1894, by operation of law, of Major John H. Bartholf, Surgeon, United States Army, under the provisions of the act of Congress, approved June 30, 1892, is announced.

First Lieutenant Paul F. Straub, assistant Surgeon, United States Army is relieved from duty at Fort Riley, Kansas, and ordered to report in person to the Commanding Officer, San Carlos, Arizona, for duty at that post, relieving First Lieutenant Hurlan E. McVay, Assistant Surgeon United States Army.

Lieutenant McVay, on being relieved by Lieutenant Straub, will report in person to the Commanding officer, Whipple Barracks, A. T., for duty at that post.

A board of officers to consist of Lieutenant Colonel R. Greenleaf, Deputy Surgeon General U. S. Army; Colonel Albert Hartsuff, Deputy Surgeon General, U. S. Army; Major Benjamin F. Pope, Surgeon, is appointed to meet at the call of the president thereof, at San Francisco, Cal., for the examination of Captain William R. Hall, Assistant Surgeon, with a view of determining his fitness for promotion, as contemplated by the act of Congress, approved October 1, 1890 and July 27, 1892.

Captain Hall will report in person to the president of the board for examination at such time as he may designate.